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Special Plans and Operations

Assessment of DoD Wounded Warrior Matters - Fort Riley

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Inspector General

United States Department of Defense

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DEPARTMENT OF DEFENSE
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August 6, 2013

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: Assessment of DoD Wounded Warrior Matters – Fort Riley
(Report No. DODIG-2013-113)

This report discusses whether the programs for the care, management, and transition of Soldiers in the Warrior Transition Battalion, Fort Riley, Kansas were managed effectively and efficiently. This report is the fifth of six site assessments conducted at Army Warrior Transition Units and Marine Corps Wounded Warrior Battalions.

We are providing this draft report for your information and use. We considered management comments on a draft of this report, when preparing the final report. Comments on the draft of this report conformed to the requirements of DOD Directive 7650.3 and left no unresolved issues. Therefore, we do not require any additional comments.

We appreciate the courtesies extended to our staff. Please direct questions to [redacted]. If you desire, we will provide a formal briefing on the results.

Kenneth P. Moorefield
Deputy Inspector General
Special Plans and Operations

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Results in Brief: Assessment of DoD Wounded Warrior Matters - Fort Riley

What We Did

We assessed whether the Warrior Transition Battalion, Fort Riley, Kansas (hereafter [WTB]) managed effectively and efficiently the programs for the medical care and transition of wounded, ill, and injured Warriors. Specifically, we evaluated the missions, policies, and processes in place to assist Warriors in Transition with their return to duty status or transition to civilian life.

What We Found

We identified several noteworthy initiatives implemented at both the Fort Riley WTB and Irwin Army Community Hospital (IACH). We also identified a number of significant challenges that require corrective action by the responsible Army Commanders to increase program effectiveness and efficiency.

What We Recommend

We recommend that the Commander, Army Medical Command (MEDCOM); Commander, Western Regional Medical Command (WRMC); Commander, Warrior Transition Command (WTC); Commander, IACH; and Commander, WTB:

- Evaluate the current and future cadre personnel requirements of the Warrior Transition Units (WTUs) to ensure that the staffing levels, including squad leaders and Nurse Case Managers, are appropriate to meet the mission for effective management and support of Soldiers during their healing and transition.
- Conduct an analysis to determine whether the WTUs and WTBs have adequate funding and other resources to support the necessary level of WTB personnel, ongoing staff training requirements, and support services in order to maintain optimal staffing levels and ratios.
- Complete the migration of the Comprehensive Transition Plan (CTP) from the Army Knowledge Online to the Army Warrior Care and Transition System.
- Review the CTP policy and guidance for relevance and effective content in supporting Soldier and Family transition needs.
- Assess the effectiveness of WTB leadership and cadre in actively engaging the Soldiers' CTP and encouraging Soldiers' involvement and adherence to the plan for a successful transition.
- Track each phase of the Integrated Disability Evaluation System (IDES) process to identify and resolve the barriers to timely IDES completion for Soldiers assigned or attached to WTBs.
- Identify obstacles within the Soldiers' MEB referral, claim development, medical evaluation, and Medical Evaluation Board (MEB) processing phases that inhibit prompt MEB completion, and provide sufficient staff support for Physical Evaluation Board

Liaison Officers and ensure that staff to Soldier ratio is sufficient to ensure timely processing of MEB packages.

- Educate Soldiers and ensure their families are educated on how to execute the IDES process to include a realistic timeline for what the Soldier can expect once the process begins. Additionally, develop a mechanism whereby a Soldier can track and be informed of their status in the IDES process.
- Develop options for increasing the number of behavioral health personnel at Fort Riley IACH to support the numbers of Soldiers requiring such care and to accelerate MEB processing.

Management Comments and Our Responses

Management comments from the Surgeon General were responsive, and no additional comments are required. Please see the Recommendations Table.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Commander, United States Army Medical Command		D.2.1.
Commander, Western Regional Medical Command		D.1.1.
Commander, Warrior Transition Command		C.1.1.a., C.1.1.b., C.2.1.a., C.2.1.b.
Commander, Irwin Army Community Hospital		D.1.2.a., D.1.2.b., D.1.2.c.
Commander, Warrior Transition Battalion		C.2.2.

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Introduction

Objectives

The broad objective of this ongoing assessment is to determine whether the DoD programs for the care, management, and transition of recovering Service members wounded during deployment in Operation Iraqi Freedom or Operation Enduring Freedom were managed effectively and efficiently.[1]

Specific Objectives

Our specific objectives were to evaluate the missions, the policies, and processes of:

- Military units, beginning with the Army and Marine Corps, established to support the recovery of Service members and their transition to duty status (Active or Reserve Components)[2] or to civilian life; and
- DoD programs for Service members affected with Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD).

Assessment Approach

This is the fifth of six site assessments conducted at Army and Marine Corps Warrior Transition Units (WTUs). This assessment addressed the wounded, ill, or injured Soldiers' matters at the Army WTB located at Fort Riley, Kansas. To obtain unbiased data, not unduly reflecting the views of either the supporters or detractors of the program, we used a two-pronged approach to select our respondents. First, we determined how many Service members to interview, and then we applied a simple random sample approach to determine the Service members we should interview, as described in Appendix A. Subsequently, we interviewed 48 individuals and 6 groups of Army wounded, ill, and injured Soldiers.

Additionally, we interviewed all available members of the key groups at Fort Riley responsible for the Soldiers' care. Specifically, we conducted meetings and interviews during our 2-week visit to Fort Riley, Kansas that included Irwin Army Community Hospital (IACH) and WTB military and civilian staff and contractors supporting the WTB. A list of the meetings conducted at the WTB and IACH located at Fort Riley, Kansas from May 10 to 20, 2011, is shown in Appendix A, along with the scope, methodology, and acronyms of this assessment. Appendix B discusses the prior coverage of this subject area.

The observations and corresponding recommendations in this report focus on what we learned at Fort Riley, Kansas. We believe that some of our observation may have implications for other WTUs and WTBs and should be called to the attention of those responsible for these programs.

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[1] Subsequent to our project announcement and at the initiation of our fieldwork, the Army's Warrior Transition Command (WTC) informed us that approximately 10 percent of the Soldiers assigned or attached to Warrior Transition Units (WTUs) were combat wounded.

[2] The Army consists of two distinct and equally important components, the Active Component and the Reserve Component (Army National Guard and the Army Reserve).

Additional reports and/or assessments may be subsequently performed by the DoD Office of Inspector General on DoD Wounded Warrior matters or other related issues as they are identified. Appendix C discusses the specific issues, concerns, and challenges that we identified at Fort Riley that may have to be addressed in future assessments and/or reports.

Background

According to the Army's Warrior Transition Command (WTC), on September 1, 2012, there were 9,852 Soldiers in transition in the Army WTUs and Community Based Warrior Transition Units (CBWTUs).[3] Of the 9,852 Soldiers in the WTUs and CBWTUs, over 1,000 Soldiers were wounded in combat, approximately 2,000 were injured or became sick and were medically evacuated[4] from theater, and approximately 2,100 returned from a deployment prior to entry into a WTU but were not medically evacuated during the deployment. Of the remaining 4,716 Soldiers who had not deployed within the last 6 months, 3,492 had deployed one or more times and 1,224 are not in the WTC program for deployment-related reasons.[5]

Army Guidance

Army guidance for the care and management of Warriors in Transition (hereafter, "Soldiers") is contained in the "Warrior Transition Unit Consolidated Guidance (Administrative)," March 20, 2009 (hereafter, "Consolidated Guidance"). The purpose of the Consolidated Guidance is to prescribe the policies and procedures for the administration of Soldiers assigned or attached to WTUs. The Consolidated Guidance addresses items such as eligibility criteria for a Soldier's assignment or attachment to a WTU, staffing ratios of Army care team members, and other administrative procedures for determining eligibility of Soldiers for assignment or attachment to a WTU. Appendix D summarizes the Consolidated Guidance requirements.

After our visit, the WTC updated their policy related to the Comprehensive Transition Plan (CTP) for Soldiers assigned/attached to WTUs and CBWTUs; and formalized a review process that facilitates the Soldiers progression through the WTU/CBWTU. The updated CTP Policy and Guidance, December 1, 2011, is explained in further detail in Parts I, II, and Appendix E of this report.

Warriors in Transition

The Army's wounded, ill, and injured Service members were referred to as Warriors in Transition (WTs) at the time of our site visit. The mission statement of a Warrior in Transition is:

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[3] Community-Based WTUs are primarily for Reserve Component Soldiers. According to the Consolidated Guidance, the Community-Based WTU is a program that allows Warriors to live at home and perform duty at a location near home while receiving medical care from the TRICARE network, the Department of Veterans Affairs, or Military Treatment Facility (MTF) providers in or near the Soldier's community.

[4] Medical evacuation is the transport of a patient to a place where medical care is available.

[5] Figures provided by the Army WTC, Program Performance and Effectiveness Branch, September 10, 2012 and July 1, 2013.

> I am a Warrior in Transition. My job is to heal as I transition back to duty or become a productive, responsible citizen in society. This is not a status but a mission. I will succeed in this mission because I am a Warrior.

As of December 1, 2011, the Army replaced the term, "Warrior in Transition" with "Soldier."

Warrior Transition Units

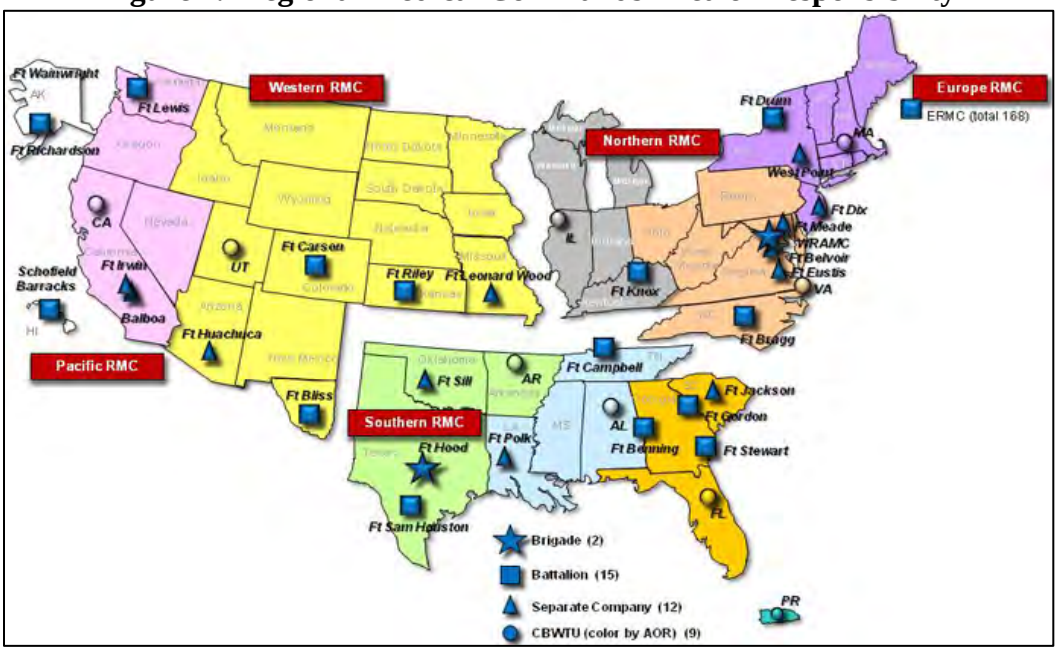
In 2007, the Army created 35 WTUs at major Army installations primarily in the Continental United States (CONUS) and at other sites outside CONUS to better support the recovery process of the Army's wounded, ill, and injured Service members. As of December 2011, there were 28 WTUs located in CONUS, 1 in Hawaii, 1 in Alaska, and 2 in Europe, as well as 8 community-based WTUs located in CONUS and 1 in Puerto Rico.

A WTU is a company-level unit and a WTB includes multiple companies or CBWTUs. A field-grade officer[6] (typically a lieutenant colonel) commands a WTB. A WTB has multiple companies or CBWTUs that report to him or her. The unit located at Fort Riley is a battalion size unit and is a WTB. Additionally, a WTU refers to a unit including the WTB. Therefore, throughout this report we will refer to WTU when citing general policy applications that apply to all units and WTB when specifically referring to the WTB at Fort Riley.
The commander of each WTB reports to the commander of the Military Treatment Facility (MTF). Army WTB care teams consist of, but are not limited to, military staff; physicians; nurses; behavioral health specialists, such as psychologists and social workers; occupational therapists, including civilians; and outside organizations offering resources to the Soldiers in support of mission accomplishment.

Figure 1 illustrates the Regional Medical Commands Area of Responsibility and their geographically aligned CBWTUs, to include Fort Riley.

[6] A military officer, such as a major, lieutenant colonel, or colonel, ranking above a captain and below a brigadier general.

Figure 1. Regional Medical Commands Area of Responsibility



Source: Warrior Transition Command – December 2011

WTUs provide support to Soldiers who meet the eligibility criteria for assignment or attachment to a WTU. The eligibility requirements are that the Soldier:

- must have a temporary physical profile; [7]
- is anticipated to receive a profile, for more than 6 months with duty limitations that preclude the Soldier from training for or contributing to unit mission accomplishment; and
- the acuity of the wound, illness, or injury requires clinical case management to ensure appropriate, timely, and effective utilization of and access to medical care services to support healing and rehabilitation.[8]

Triad of Care

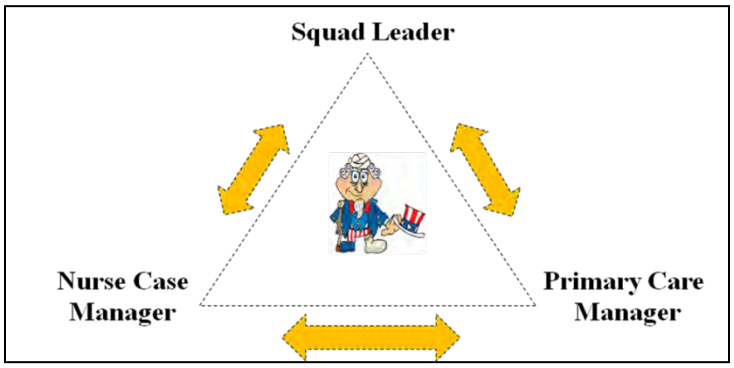
The Army established the Triad of Care concept to envelop the Soldiers and their families in comprehensive care and support which focuses on each Soldier's primary mission – to heal and transition. The "Triad of Care" consists of a squad leader, a nurse case manager (NCM), and a primary care manager (PCM). Within the "Triad," the squad leader leads Soldiers, the nurse

[7] According to Army Regulation 40-501, "Standards of Medical Fitness," December 14, 2007, the basic purpose of the physical profile serial is to provide an index to overall functional capacity. The physical profile serial system is based primarily upon the function of body systems and their relation to military duties. The six factors evaluated are physical capacity or stamina, upper extremities, lower extremities, hearing, and ears, eyes, and psychiatric. Profiles can be either permanent or temporary.

[8] Army National Guard and Army Reserve Soldiers may be eligible for assignment or attachment to a WTU but fall under a different and more complex process than Active Component Soldiers. The Consolidated Guidance provides the processes for assignment or attachment to a WTU.

case manager coordinates their care, and the primary care manager oversees the care. Specifically, the Triad of Care works together as a team to collect Soldier data and information and develop a plan of care specific to each Soldier. The plan of care addresses medical treatment, administrative requirements, support needs, and disposition. The intent is for all of these elements to work together to ensure advocacy for the Soldiers, continuity of care, and a seamless transition back into the force or to a productive civilian life. Figure 2 shows the Triad of Care structure.

Figure 2. Triad of Care



Source: Brooke Army Medical Center, Warrior Transition Battalion Handbook, June 2010

Fragmentary Order (FRAGO) 3 to Execution Order (EXORD) 188-07, March 20, 2009, established the WTU Triad of Care staff to Soldiers ratios at: squad leader (1:10), nurse case manager (1:20), and primary care manager (1:200).

The following is a brief description of each Triad of Care member's roles and responsibilities.

- **Squad Leader –** a non-commissioned officer (NCO) in the rank of sergeant (E-5) or staff sergeant (E-6) and is the first line supervisor for all Soldiers. Their duty description includes but is not limited to accounting for Soldiers daily, counseling them and guiding them in their CTP,[9] ensuring that they attend all appointments, tracking all of their administrative requirements, and building trust and bonding with Soldiers and their families.
- **Nurse Case Manager (NCM) –** a civilian or Army nurse who provides the individualized attention needed to support the medical treatment, recovery, and rehabilitation phases of care of the Soldiers. The goal of case management is to orchestrate the best care for the Soldiers by monitoring progression of care, Transition

[9] The CTP supports Soldiers in returning to the force or transitioning to a Veterans' status. Although standardized, the CTP allows each Soldier to customize his or her recovery process, enabling them to set and reach their personal goals with the support of the WTU cadre. For additional information on the CTP, see Observations A, C and Appendix E.

Review Board[10] recommendations, and Soldiers' respective goals to facilitate transition of the Soldier from one level of care to the next.

- **Primary Care Manager (PCM) –** is either a military or a civilian healthcare provider (for example, physician, physician assistant, or nurse practitioner) who is the medical point of contact and healthcare advocate for the Soldier. They provide primary oversight and continuity of healthcare and are to ensure the level of care provided is of the highest quality. They are the gateway to all specialty care (such as behavioral health specialists or orthopedic surgeons) and they coordinate with other care providers to ensure that the Soldiers are getting the treatment that they need.

Fort Riley, Kansas

Fort Riley, Kansas, is located 12 miles west of Manhattan, Kansas, in the northeastern part of the state. The Army 1st Infantry Division, famously known at the "Big Red One," and its supporting units have been the post's main division since 2006. The mission of 1st Infantry Division is to deploy, conduct full spectrum operations as part of a Combined Joint Task Force or designated force headquarters, and transition to follow-on operations. Fort Riley has connections to the Oregon and Santa Fe Trails, and for the famed "Buffalo Soldiers," that trained for patrolling these important travel and economic routes.

The Army named Fort Riley in honor of Maj. Gen. Bennett C. Riley who led the first military escort along the Santa Fe Trail in 1829. The First Infantry Division and Task Force Danger conducted operations in Iraq from 2003 to 2005. The Division led the largest air/combat insertion of an armored heavy task force in U.S. Army history. Fort Riley also boasts an extensive Resiliency Campus that seeks to improve comprehensive fitness of service members and their families.

Additionally, the Soldier and Family Assistance Center (SFAC) provide Fort Riley Soldiers and their families with a "one stop shop" for linkage to care and support services at the WTB. Their mission is to provide the Soldier with a clear path back to the military force or to civilian life, and providing an infrastructure of support for our Nations' heroes. Services available to assist Soldiers include educational programs, financial services, and family support programs such as Spouses Understanding Needs.

Surrounding Area

Fort Riley is located less than 5 miles from Junction City, Kansas, which has a population of just over 23,000. Junction City is one of the "Top 200 Towns in America to Live for Anglers and Hunters" by *Outdoor Life* magazine. Local Milford Lake is the Fishing Capital of Kansas. Geary Community Hospital is located here. The hospital has a capacity of 65-staffed beds, and provides clinical and specialty services including neuroscience, psychiatry, orthopedics, radiology, and intensive care.

[10] Transition Review Boards are intended to facilitate dialogue between the Warrior and the Triad of Care, chain of command, and other members of the Warrior's care team, as appropriate, regarding both the Comprehensive Transition Plan progress and future strategy for the Warrior's transition.

Manhattan, Kansas, is approximately 10 miles northeast of Fort Riley, has a population of 50,000, and is home to the main campus of Kansas State University. The Mercy Regional Health Center and the Manhattan Surgical Center are located here. Mercy Regional Health Center is a 111-bed facility with services such as Emergency, Neuroscience, Oncology, Orthopedics, Radiology, Intensive Care, and Wound Care. Manhattan Surgical Center has an additional 13 specialty beds.

Salina, Kansas, is located about 50 miles west of Fort Riley. Salina is the regional trade center in north central Kansas centered in one of the largest wheat producing areas of the world. Salina Regional Health Center is a 204-bed hospital, offering services in Emergency, Neuroscience, Oncology, Orthopedics, Radiology, Rehabilitation/Physical Therapy, Intensive Care & Neonatal Intensive Care, Psychiatry, and Wound Care. Salina Surgical Hospital provides an additional 15-bed capability.

Located about 70 miles east of Fort Riley is Topeka, Kansas, and 130 Miles northwest of Fort Riley is Leavenworth, Kansas. The Veterans Administration (VA) Eastern Kansas Health Care System operates the Dwight D. Eisenhower VA Medical Center in Leavenworth, Kansas, and the Colmery-O'Neil VA Medical Center in Topeka, Kansas. These facilities provide a wide range of inpatient and outpatient services with a focus on primary and secondary care, psychiatric treatment, and extended care supported by nursing home care units and a domiciliary.

Kansas City, with a population of about 150,000, is located about 130 miles east of Fort Riley. The University of Kansas Hospital has approximately 576 staffed beds and provides clinical and specialty services including Emergency, Neurosciences, Oncology, Organ Transplant, Orthopedics, Radiology, Rehabilitation, Intensive Care, Burn Intensive Care, Neonatal Intensive Care, Pediatrics Intensive Care, Psychiatry, Wound Care, and Hyperbaric Oxygen.

Western Regional Medical Command

Joint Base Lewis-McChord (JBLM) is the central headquarters for the Western Regional Medical Command (WRMC). The Command covers 20 states, and is geographically the largest of the Army's three regional medical commands in CONUS. Its two-star commanding general has oversight of nine Army medical treatment facilities, two medical detachments, and other medical assets within the region. The Commanding General, WRMC also provides oversight for the healthcare delivery process of Active, and Reserve Component Soldiers, retirees, and their families.

There are 10 WTUs and two CBWTUs in the WRMC serving over 2,000 Soldiers. As of April 6, 2012, CBWTU-California oversees approximately 268 Soldiers receiving care in California, Nevada, Oregon, and Washington. CBWTU-Utah manages the care of approximately 215 Soldiers, covering 13 western and central states. The Fort Riley WTB and Irwin Army Community Hospital (IACH) at Fort Riley are part of the WRMC.

Irwin Army Community Hospital

The Army built the Irwin Army Community Hospital (IACH) in 1955 and a new outpatient clinic wing in 1978. In the spring 2014, the opening of a new medical facility is projected to include 57 beds with services including Urgent Care/Emergency Medicine, and Radiology including CT, MRI, and a Traumatic Brain Injury Center.

The Mission of IACH is to provide healthcare for Soldiers, military families, and retirees, and support the deployment of medically ready forces. The outpatient wing of the hospital maintains 49-staffed beds, and 17 of the 23 outpatient clinics at IACH. Four primary medical care facilities are located throughout the local surrounding area.

Warrior Transition Battalion Fort Riley

Fort Riley is home to the Army's first permanent WTB complex built in 2010. The complex includes barracks where Soldiers can stay during their recovery. Fort Riley also maintains a Resiliency Campus that seeks to increase resilience and enhance performance by strengthening the five dimensions of strength which are physical, emotional, social, family, and spiritual strength. The Resiliency Campus provides many services and tools that Soldiers and their families can use to grow and maintain their well-being.

As of April 2012, 22 of the 25 authorized Nurse Case Managers (NCMs) and 28 of the 33 authorized Squad Leaders staffed the Fort Riley WTB Triad of Care. The WTB consisted of a headquarters company and three additional companies (Alpha, Bravo, and CBWTU-Utah) that collectively provided unit leadership and focused on meeting the command and control functions.

Between June 1, 2007, and December 31, 2012, 1,735 Soldiers transitioned through the Fort Riley WTB. Of the 1,735 Soldiers, 1,277 were active duty, 302 were National Guard, and 156 were Reservists. Table 1 shows the total number of Soldiers and their Army Component that transitioned through the Fort Riley WTB.

Table 1. Total Number of Soldiers Transitioning Through the Fort Riley WTB Between June 1, 2007 and December 31, 2012

Army Component	Total Transitioning
Active Duty	1,277
National Guard	302
Reservists	156
Total Soldiers Transitioning	**1,735**

Source: Warrior Transition Command

Traumatic Brain Injury and Post Traumatic Stress Disorder

TBI[11] and PTSD[12] are common diagnoses for recovering Service members. TBI is also referred to by its common term, "concussion," which is when someone receives a direct blow or a jolt to their head that disrupts the function of the brain. Service members may sustain concussions or TBIs when exposed to a blast or explosion (sometimes on multiple occasions), which may lead to serious symptoms. There are three different levels of TBI (mild, moderate, and severe) based on the severity of damage to the brain.

PTSD is an anxiety disorder or condition that may develop after someone has experienced or witnessed a life-threatening or traumatic event, which may include a combat event. PTSD usually begins immediately after the traumatic event but it could start later, even years later. A PTSD event likely involved actual or perceived death or serious injury and caused an intense emotional reaction of fear, hopelessness, or horror.

Virtual Behavioral Health is a Western Regional Medical Command initiative that enables medical providers to conduct behavioral health screening while located at an installation other than the Soldier's Readiness Processing site using high-definition video cameras. This allows behavioral health assets in the region to maintain continuity of care with Soldiers and family members during their redeployment cycle.

IACH provides additional Behavioral Health Services including PTSD and depression screening, medication management, and weekly case consultation with behavioral health, and care management. In addition, IACH initiated several new programs, which included an intensive outpatient treatment for PTSD, modeled after the Deployment Health Clinical Center program at Walter Reed, and comprehensive pain management services, which focus on the use of complementary and alternative medicine therapies to minimize the use of narcotic pain medications.

IACH has a mild Traumatic Brain Injury (mTBI) Clinic staffed with a registered nurse, physical therapist, physician assistant, psychologist, and administrative personnel. The mTBI clinic is in addition to other dedicated IACH behavioral health support available to the WTB. The mTBI clinic support includes conducting initial intakes.

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[11] The definition of TBI is from multiple sources, including "Types of Brain Injury," Brain Injury Association of America, October 15, 2008; and "Force Health Protection and Readiness Quick TBI and PTSD Facts," Force Health Protection and Readiness, October 15, 2008.

[12] The definition of PTSD is from multiple sources, including "Force Health Protection and Readiness Quick TBI and PTSD Facts," October 15, 2008; and Jessica Hamblen, PhD, "What is PTSD?" National Center for PTSD, U.S. Department of Veterans Affairs, October 15, 2008.

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Part I - Noteworthy Practices

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Observation A. Noteworthy Practices for the Fort Riley Warrior Transition Battalion

We observed two noteworthy practices that the Fort Riley WTB instituted to assist wounded, ill, or injured Soldiers in their treatment for transition back to the Army or civilian life. Those practices are:

A.1. WTB Evaluation and Assignment Practices for Soldiers

A.2. The Fort Riley Commanding General's Personal Involvement in Triad of Leadership Board Meetings

These noteworthy practices may be applicable for implementation and utilization at other U.S. Army Wounded Warrior locations.

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A.1. WTB Evaluation and Assignment Practices for Soldiers

The Fort Riley WTB Interdisciplinary Team met regularly to evaluate the Soldiers' medical needs and transition goals and to assign them to the platoon within the WTB best suited to support those medical needs and transition goals. Specifically, the meetings provided the Triad of Care support team opportunities to:

- determine the medical needs and transition goals of the Soldiers,
- assign the Soldiers to a platoon based on their transition needs of either returning to the Army or civilian life, and
- assess the Soldiers' capabilities to participate in physical training.

The WTB's assignment of Soldiers to a platoon based on their transition goals provided an environment where Soldiers with similar goals could focus on those goals while getting dedicated attention to achieve those goals. In addition, the WTB had physical training policies that considered the effects of the Soldiers' medication and physical training profile and the Soldiers' ability to participate in physical training sessions.

As a result, the WTB created a favorable support environment for wounded, ill, or injured Soldiers to successfully transition back to the Army or civilian life.

A.1. Background

2009 Consolidated Guidance Planning Requirements

According to the consolidated guidance, the WTB is to establish conditions that facilitate the Soldiers' healing process physically, mentally, and spiritually. In addition, the consolidated guidance required the WTB to provide a Triad of Warrior Support (Triad of Care)[13] that worked together to advocate for Soldiers in Transition, continuity of medical care, and transition back to the force or return to a productive civilian life. The Triad of Care must work together to develop a plan specific to each Soldier based on the information obtained about the Soldier's medical treatment and other support needs.

March 2011 Comprehensive Transition Plan Policy Planning Requirements

The consolidated guidance required the Triad of Care to develop a plan of care but did not state how to develop that plan. Later, the March 2011 CTP policy required the use of scrimmage meetings to develop and implement the plan. The scrimmage is a formal meeting with the Soldiers Triad of Care and interdisciplinary team[14] members to develop goals and measures of success for the Soldiers during their time in the WTB and after their transition back to the force or to civilian life. The interdisciplinary team used the scrimmage meetings to validate the Soldiers goals, highlight completion benchmarks and tasks, and refine the Soldiers plans. At Fort Riley, the Triad of Care held the scrimmage with the social workers, occupational therapists, and other healthcare professionals as necessary. During the scrimmages, the Triad of

[13] The Triad of Care consists of the Platoon Sergeant/Squad Leader NCM and PCM.

[14] Interdisciplinary team members include the Triad of Care consisting of the Squad Leader, NCM, and PCM along with the Occupational Therapist Registered (OTR) or Certified Occupational Therapy Assistant (COTA), Clinical Social Worker (CSW), and transition coordinator.

Care attendees discussed the Soldiers' short and long-term needs and goals. Afterwards, the Soldiers received assignments to the most appropriate company and platoon within the WTB based on the decisions made during the scrimmage meetings.

Initial Mention of Scrimmage Meeting Requirements in December 2011

The December 2011 CTP policy describes the purpose of the initial scrimmage as the medical and mission command plans that set the stage for assignment or movement to a WTB. The initial scrimmage covers a 30-day period that:

- begins with social work, behavioral health, and basic and clinical needs assessments by the members of the Triad of Care;
- includes the Soldiers completing the self-assessment portion of the comprehensive transition plan;
- requires the completion of a Soldier's physical training program consistent with the Soldier's transitions goals within 21 days; and
- requires the scheduling of an appointment with the career counselor.

A.1. Discussion

Scrimmage Process at the Fort Riley WTB

Soldiers receive assignments to a platoon and company based on the short- and long-term goals identified from their individual self-assessment and from the scrimmage meetings. During the scrimmage, Triad of Care and interdisciplinary team members determine the treatment plan needed for each Soldier. The Soldier was also an active participant in discussion of their individual goals and activities, which ultimately the Soldiers described as an effective process for properly assigning them to the correct company or CBWTU.

Social workers had the responsibility to schedule and organize the follow-on scrimmages to validate the Soldiers' goals and to develop and refine plans for Soldier transition outcomes. The scrimmage frequency depends on the Soldiers' medical risk[15] levels. At Fort Riley, the Triad of Care conducted scrimmages for high-risk Soldiers every week, moderate risk Soldiers monthly, and moderate/low- and low-risk Soldiers quarterly. See the following table for medical risk level and scrimmage frequency.

[15] "Risk is defined as the probability of harm or injury." The identification of risk level and management for Soldiers is a collaborative process among the Commander, Triad of Care and WTU/CBWTU Licensed Clinical Social Worker (LCSW) and is based on four critical components: Screening, Assessment, Management/Mitigation, and Reassessment.

Table 2. Summary of Soldiers' Medical Risk Levels, Scrimmage Frequency, and Scrimmage Attendees

Medical Risk Level	Scrimmage Frequency	Attendees
High Risk	Weekly	• Company Commanders • Battalion Surgeons • Nurse Case Managers • Senior Nurse Case Managers • Social Workers • VA Liaison • Ombudsman • Squad Leaders
Moderate Risk	Monthly	• Squad Leaders • Nurse Case Managers • Social Workers • Battalion Surgeon • Occupational Therapist
Moderate/Low Risk	Quarterly	• Squad Leaders • Nurse Case Managers • Social Workers • Battalion Surgeon • Occupational Therapist
Low Risk	Quarterly	• Squad Leaders • Nurse Case Managers • Social Workers • Battalion Surgeon • Occupational Therapist

Source: Summarized from an Interview with Warrior Transition Unit Social Workers

Squad, Platoon, and Company Assignment

A squad leader in the Bravo Company explained that the 1st Platoon, Bravo Company, was specifically for Soldiers who were capable of and planning to return to duty. The rest of the Bravo Company platoons were for Soldiers who were going to separate or retire from the Army.

WTB practice included assigning NCMs to platoons. The NCM team lead said that having squad leaders and NCMs aligned by platoon had been very helpful in the performance of their duties, improved communication, and enhanced the NCM support provided.

Physical Training Participation and Requirements

WTB staff and each Company took into consideration the Soldiers' physical status, medical status, and physical training needs when requiring them to participate in physical training (PT) formations. One company commander commented that Soldiers complete a form that explains the medications they are on and why they cannot participate in early morning PT formations. For example, PT usually occurred in the early morning, which would result in Soldiers on sleep medication to give up taking the medication to be present at the early formations. However, both Alpha and Bravo Companies had provisions for Soldiers on a medical profile to report to the squad leaders or report for duty later in the day. Squad leaders emphasized that for those Soldiers unable to participate in morning PT, accommodations were made for PT in the

afternoon. In addition, separating Soldier PT into one of three different capability groups facilitated their recovery and transition goals.

A.1. Conclusion

The Fort Riley WTB adopted the use of the scrimmage. The scrimmage enabled the WTB staff to plan support requirements for Soldiers assigned to the WTB. This initiative allowed the Fort Riley WTB staff to more accurately assess the Soldiers' needs and goals and provide appropriate support for achieving the Soldiers' transition goals. In addition, the WTB permanently assigned squad leaders and NCMs to the same platoons which provided stability and support for recovering and transitioning Soldiers. WTB Company policy provided flexibility in physical training programs to provide Soldiers alternatives to traditional early morning physical training by consideration of their specific medical limitations.

A.2. The Fort Riley Commander's Personal Involvement in Triad of Leadership Board Meetings

The Fort Riley Senior Mission Commander or another General Officer representing the Commander chaired all Triad of Leadership (TOL) Board Meetings making the eligibility determination process for assigning Soldiers to the WTB. Consequently, the participation of the highest authority at Fort Riley in determining eligibility set the environment for proper management of the selection process for assignment of Soldiers to the WTB in accordance with the letter and spirit of the Army Consolidated Guidance. As a result, Soldiers who could most benefit from the specialized services of the WTB received assignment to the WTB.

A.2. Background

The consolidated guidance included and put into effect the requirements of Headquarters, U.S. Army Medical Command FRAGO 3 to EXORD 118-07. The consolidated guidance required that the TOL board process use specific eligibility criteria to assign only Soldiers that needed the unique services of the WTB. The WTB has limited resources, and determining how best to utilize these resources is of upmost importance for efficiency and effectiveness.

A.2. Discussion

Triad of Leadership Board

We observed the May 16, 2011, meeting of the TOL Board that reviewed application packages from Soldiers requesting assignment to the WTB. The Commanding General (CG), 1st Infantry Division (1st ID) led this TOL Board session. Typically, the CG, 1st ID, or another general officer led TOL Board meetings. Other TOL board members included the IACH Commander, the WTB Commander, and the Command Sergeants Major for the 1st ID, IACH, and the WTB. A squad leader or senior non-commissioned officer and the first officer in the applicant's chain of command accompanied each applicant.

During the TOL Board meeting, TOL members reviewed the applications. Immediate supervisors presented comments to support assigning the Soldiers to the Fort Riley WTB versus keeping them in their current units. After the supervisors departed, the TOL Board directed the applicants to present their justification for requesting assignment to the WTB.

Perceptions of Triad of Leadership Board Assignments

Most Soldiers assigned to the Fort Riley WTB for care that we interviewed believed that the WTB provided the appropriate program to support their healing and transition goals. One Soldier indicated that the WTB provided effective support for getting through the physical evaluation board process but stated that he would be better off at his home unit for his medical treatment.

Staff officers at Fort Riley responsible for preparing orders to assign Soldiers to the WTB stated that the TOL Board reviewed applications of Soldiers who had the complex care and case management requirements that could be best supported by a WTB. The staff said that the TOL Board strived to identify the higher risk active duty Soldiers with more complex conditions for entry into the WTB. By assigning only those wounded, ill, or injured Soldiers with the greatest

need provided for better use of the WTB's limited resources and potentially optimized support for these Soldier's recovery and transition.

A.2. Conclusion

Fort Riley implemented the TOL Board screening and assignment processes effectively and in accordance with the letter and spirit of the consolidated guidance. Leadership by the CG, 1st ID, or another general officer had a positive impact on the TOL Board screening and selection processes. Direct engagement by high level command authority ensured selections were made consistent to the letter and intent of Army guidance. Most Soldiers assigned to the WTB said they believed that the WTB structure was effective for managing their healing and transition needs versus staying at their military home units. In addition, the WTB staff said that the TOL Board endeavors to select the Soldiers with the greatest case management needs. The personal involvement of the senior leadership at Fort Riley inspired due diligence by the TOL Board and is in keeping with the intent of the Army to provide the specialized case management services of the WTB to the most seriously wounded, ill, and injured Soldiers to support their healing and transition.

Observation B. Noteworthy Practices for the Fort Riley Irwin Army Community Hospital

We observed four noteworthy practices instituted at Fort Riley's Irwin Army Community Hospital that helped to ensure Soldiers received quality medical and transition services.

B.1. Equal Access to Care

B.2. Medication Reconciliation Procedures

B.3. Augmenting Military Behavioral Health Support with Civilian Facilities

B.4. Co-location of Department of Veterans Affairs and Medical Department Activity (MEDDAC) Transition Services

These noteworthy practices may be applicable for implementation and utilization at other U.S. medical treatment facilities.

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B.1. Equal Access to Care

Based on our interviews with Fort Riley WTB Soldiers and WTB support staff, we did not note any differences in access to medical care for Active and Reserve Component Soldiers at Irwin Army Community Hospital.

B.1. Background

In May 2010, Senator Ron Wyden and Congressman Kurt Schrader requested that we investigate medical treatment entitlements for all Guard and Reserve Soldiers at all Warrior Transition Units and mobilization and demobilization sites. As part of our ongoing assessment project, the DoD Inspector General remained focused on the concerns regarding the management of Reserve Component (RC)[16] Soldiers in the Warrior Transition Units.

At the time of our site visit there were 339 Soldiers assigned or attached to the WTB at Fort Riley; 214 active duty, 88 National Guard, and 37 Reservists. Between June 1, 2007, and December 31, 2012, 1,735 Soldiers transitioned through the Fort Riley WTB. Of the 1,735 Soldiers, 1,277 were active duty, 302 were National Guard, and 156 were Reservists.

B.1. Discussion

In May 2011, we interviewed 75 active duty and 64 National Guard/Reserve Soldiers assigned or attached to the WTB at Fort Riley. During individual and group interviews, active duty, National Guard, and Reserve Soldiers stated that they had equal access to medical care.

Soldiers on active duty generally have continuous access to the MTFs and the period of occurrence of the illness, injury, or disease is not a factor for receiving care. However, according to the consolidated guidance, RC Soldiers eligibility for medical care at the MTFs or the WTUs depends on whether the illness, injury, disease, or aggravated pre-existing medical condition occurred in the line of duty and have been identified and documented in the medical records. In addition, RC Soldiers eligibility for access to care at the MTFs is contingent upon the period of time that has expired after discovery of the illness, injury, disease, or aggravated pre-existing medical condition. The Army programs used to provide RC Soldiers access to medical care at MTFs are the Active Duty Medical Extension (ADME) and the Medical Retention Processing2 (MRP2). The ADME program voluntarily places Soldiers on temporary Active Duty, to evaluate or treat RC Soldiers with in-the-line-of-duty service connected medical conditions or injuries. To be eligible, the RC Soldiers must apply for and receive approval from a medical review board.

The MRP2 program voluntarily return RC Soldiers back to temporary active duty, to evaluate or treat unresolved mobilization connected medical conditions or injuries that were either not identified or did not reach optimal medical benefit prior to their release from active duty. The RC Soldier has 6 months from the date of release from active duty to submit an application. The Soldier must still be a member of the Selected Reserves or Individual Ready Reserve (IRR).

[16] The Army consists of two distinct and equally important components, the Active Component and the Reserve Component (Army National Guard and the Army Reserve).

The ADME and the MRP2 are the programs used to provide RC Soldiers access to medical care. Furthermore, when at the WTB, RC Soldiers have equal access to care.

Fort Riley Medical Staff Comments on Access to Care

The Fort Riley Irwin Army Community Hospital medical staff that we interviewed stated that the active duty and RC Soldiers had the same access to medical care. The Fort Riley PCMs that we interviewed said that there was no difference in access to medical care for the RC Soldiers as compared to the active duty Soldiers. Furthermore, the Fort Riley mTBI Clinic staff that we interviewed said that the RC Soldiers sometimes received quicker access to behavioral health treatment because the RC Soldiers needed the behavioral health treatment to enroll in remote care[17] facilities away from Fort Riley.

Finally, the Fort Riley Behavioral Health Team all agreed that, in their opinion, there was no difference in access to medical care for the RC Soldiers, as compared to the active duty Soldiers.

Support Personnel Comments on Access to Care

The Soldier and Family Assistance Center (SFAC) develops training, coordinates access to community resources, and serves as a source of information, referrals, outreach, and advocates for Soldiers assigned to the WTB. The SFAC also provides classes, briefings, counseling, and transition plans based on the Soldiers' needs and goals. All of the SFAC personnel we interviewed indicated that there was no difference in access to medical care for active and RC Soldiers. In addition, the Fort Riley Hospital Chaplain did not perceive any differences in access to medical care for the RC Soldiers as compared to the active duty Soldiers.

We interviewed both the Army Wounded Warrior Program (AW2) Soldier Family Advocate for the Warrior Transition Command and the AW2 Advocate for the WTB. Neither of them had detected any difference in the medical care and services provided to the active and RC Soldiers.

WTB Soldiers' Comments on Access to Care

Overall, the Soldiers we interviewed indicated no inequality in access to medical care and medical care delivery between Components. It was the consensus of the Active and RC Senior NCOs and officers that there was no difference in the medical care and services provided to the active and RC Soldiers.

Similarly, the active duty NCOs (pay grade E-5 through E-7) and the active duty enlisted Soldiers (pay grade E-1 through E-4) said that all Soldiers had equal access to medical care and treatment within the Fort Riley medical facilities. One National Guard Soldier stated that the medical providers treated all WTB Soldiers like they are active duty.

An active duty lieutenant colonel (pay grade O-5) stated that differences were not evident in care and that there should be equality among all Soldiers in the WTB. Additionally, an RC major

[17] Remote care is a managed care option, bringing benefits of TRICARE Prime in designated remote locations. In designated remote locations in the United States; usually more than 50 miles or one hour's drive time, from a military hospital or clinic.

(pay grade O-4) said that access was equal for all Soldiers; he further explained that he expected no difference in treatment and that respect and care should be the same for everyone.

One Active duty chief warrant officer said that he had not heard of a difference concerning equal access and medical treatment within the Fort Riley medical facilities. Another RC chief warrant officer stated that the active duty and the RC Soldiers all had equal access to medical treatment and that everyone was treated the same.

Others Comments on Care

Subsequent to our site visit to the WTB at Fort Riley, we met with the National Guard Bureau Chief Surgeon on November 15, 2012, and the Oregon National Guard, Joint Forces Headquarters on November 28, 2012. During these meetings, they expressed no concerns about the management of Guard and Reserve Soldiers with respect to their access to WTU resources.

B.1. Conclusion

The Soldiers we interviewed stated they received equitable access to medical care for the condition(s) that required their assignment or attachment to the WTB. Furthermore, the medical and administrative personnel also concurred that equitable access to medical care was provided to active and RC Soldiers. We concluded that active and RC Soldiers received equal access to medical care while assigned to the WTB at Fort Riley. Nevertheless, we recommend continuing analysis of patient satisfaction surveys in order to detect any possible future problems and appropriately address them as they occur.

B.2. Medication Reconciliation

Fort Riley IACH medical personnel developed and implemented standard operating procedures and medication profile management to ensure accurate medication usage for Soldiers assigned to the Fort Riley WTB. As a result, the Fort Riley IACH medical personnel reduced and mitigated the risk of negative medication interactions and reactions for Soldiers assigned to the Fort Riley WTB.

B.2. Background

The Joint Commission, an independent, not-for-profit organization that sets standards and is an accreditation body in healthcare, issued a Sentinel Event Alert dated January 25, 2006, regarding the use of medication reconciliation to prevent errors.

The Joint Commission alert encouraged the implementation of medication reconciliation, the process of comparing a patient's medication orders to all of the medications that the patient has been taking. The purpose of the reconciliation is to minimize medication errors such as omissions, duplications, dosing errors, and drug interactions. Medical reconciliation should occur at every transition of care in which new medications are ordered or existing orders are renewed. Transitions in care include changes in setting, service, practitioner, or level of care. This process consists of five steps.

1. Develop a list of current medications.
2. Develop a list of medications to be prescribed.
3. Compare the medications on the two lists.
4. Make clinical decisions based on the comparison.
5. Communicate the new list to appropriate caregivers and to the patient.

B.2. Discussion

IACH took proactive measures to ensure proper reconciliation of medications for Soldiers that minimized their risk for adverse medication interactions or reactions. These measures included implementing standard operating procedures (SOPs)[18] that Fort Riley IACH medical and WTB personnel used for dispensing medications to Soldiers or managing their availability to Soldiers. Furthermore, IACH medical and WTB personnel proactively identified situations where Soldiers could be at risk for adverse outcomes and took appropriate action to mitigate those risks.

Standard Operating Procedures

IACH and the WTB used five SOPs that addressed medication reconciliation to prevent errors in medication dispensing and to ensure the safety of the Soldier. The SOPs are:

- Fort Riley Warrior Transition Battalion's "WTB Poly-Pharmacy Consult Protocol," September 23, 2010, describes the criteria used by the unit's pharmacist to identify

[18] Standard Operating Procedure-A set of instructions covering those features of operations, which lend themselves to a definite or standardized procedure without loss of effectiveness. The procedure is applicable unless ordered otherwise. Also called SOP.

Warriors who may be at increased risk due to poly-pharmacy[19] and defines risks mitigating strategies for the Warrior Transition Battalion.

- Fort Riley Medical Department Activity's "Standard Operating Procedure for Warriors in Transition," October 29, 2010, outlines the procedures for medication reconciliation and filling/dispensing of prescriptions for Soldiers. This policy was developed in accordance with Office of the Surgeon General/U.S. Army Medical Command (OTSG/MEDCOM) Policy Memo 09-22, "Warriors in Transition High Risk Medication Review and Sole Provider Program;" MEDDAC Regulation 40-120, "Sole Provider Program;" and WTC Policy Memo 10-033, "Warrior Transition Unit Risk Assessment and Mitigation Policy."

- Fort Riley Irwin Army Community Hospital's "Standard Operating Procedure Sole Provider Program," November 1, 2010, provides a systematic method to detect any significant trends indicating an increased use of controlled substances or other drugs and treatment of patients with documented heavy use of controlled substances or other drugs of potential abuse.

- Fort Riley Medical Department Activity's "Standard Operating Procedure for Warriors in Transition Medication Dispensing," January 2011, outlines procedures for medication dispensing due to quantity restrictions on controlled medications and the requirement for Soldiers to fill their prescriptions at Fort Riley in accordance with OTSG/MEDCOM Policy Memo 90-22, "Warriors in Transition High-Risk Medication Review and the Sole Provider Program."

- Fort Riley Irwin Army Community Hospital's "Standard Operating Procedures for Receiving Medications from WTU Soldiers," May 20, 2011, outlines methods of receiving unused mediations back from the WTB Soldiers.

Resolving Overmedication Concerns

Fort Riley IACH medical staff expressed their concern about the amount of medication provided to Soldiers by an off-post civilian behavioral healthcare clinic. IACH medical staff subsequently resolved the concern by meeting with the civilian provider. Furthermore, the IACH medical staff conducted a quality-of-care review and determined that the care provided at the civilian clinic met the treatment standards for the treatment of the Soldiers' medical conditions. The IACH staff indicated that they believed that the perceptions of over-medication had decreased due to the involvement of the civilian network providers in the Behavioral Health Group meetings. These meetings increased dialogue among all the providers and facilitated communication to provide better treatment to the Soldiers.

Proactive Involvement of Medical Staff

Fort Riley IACH medical staff implemented measures to decrease risks from medications to Soldiers. These measures included:

[19] According to http://medical –dictionary.thefreedictionary.com/polypharmacy, Mosby's Medical Dictionary, 8th edition defines "Poly-pharmacy" as the use of a number of different drugs, possibly prescribed by different doctors and filled by different pharmacies, by a patient who may have one of several health problems.

- collaboration between various medical and other support staff regarding review of medication prescribed to high-risk Soldiers, and
- monitoring the amount of medication provided to high-risk Soldiers to prevent misuse.

The Fort Riley mTBI Clinic staff explained that medication reconciliation occurred with the provider during each Soldier's visit to the mTBI Clinic. In addition, the mTBI Clinic providers communicated with other providers when questions occurred about Soldier's prescribed medications. The mTBI Clinic staff conducted weekly interdisciplinary meetings to review each Soldier's plan of care and utilization of resources within the Fort Riley IACH. Whenever they became aware that a Soldier received treatment outside the Fort Riley IACH for behavioral health reasons, they contacted the facility to inquire about the Soldier's behavioral health treatment.

Primary Care Manager Roles

The WTB PCMs explained that there was formal and informal dialogue between the Fort Riley pharmacies and the PCMs for medication reconciliation and review of potential over medication or drug-to-drug adverse interactions for the Soldiers.

Pharmacist Roles

The Fort Riley pharmacist conducted weekly reviews of each Soldier deemed to be high-risk and for those on controlled medications. The pharmacist utilized the Pharmacy Medication Analysis & Reporting Tool (PMART)[20] to identify all Soldiers prescribed controlled medications. The pharmacist also collaborated with the PCMs and NCMs to discuss the Soldiers' medication profile in an effort to ensure Soldiers' safety. In addition, the pharmacist contacted prescribing providers anytime the pharmacy was unsure of the types of medications prescribed to Soldiers. Finally, as part of the medication reconciliation review, the pharmacist took steps to discontinue medication on a Soldier's medication profile that the Soldier was no longer using.

[20] The Department of Defense, Pharmacoeconomic Center developed the WTU-PMART in order to support the Warriors in Transition High Risk Medication Review and the Sole Provider Program. The WTU-PMART application provides the WTU healthcare provider with medication information and identifies potential at risk patients, and compliance to the sole provider program. The database is only accessible to healthcare providers who are involved with the care of a WTU service member. The WTU-PMART provides prescription on the WTU service member from all points of service; identifies high-risk individuals; specialized medication reports focused on high risk medications (that is, narcotic use, sleep aids, etc.)

B.2. Conclusion

Fort Riley IACH had developed and implemented SOPs and local practices that effectively addressed medication reconciliation for Soldiers. Furthermore, Fort Riley IACH medical personnel adhered to the intent of the SOPs and fully implemented the local policies and procedures for medication reconciliation to ensure the safety of each Soldier. The Fort Riley IACH medical staff was actively involved in mitigating risks associated with multiple medications prescribed to Soldiers.

B.3. Augmenting Military Behavioral Health Support with Civilian Facilities' Support

Soldiers assigned to the WTB had access to off-post civilian providers in the community surrounding Fort Riley for behavioral health care.

This was a result of proactive actions by the Deputy Commander for Clinical Services (DCCS) at IACH to include civilian providers in an expanded behavioral health network.

Therefore, additional behavioral health appointment options were available to Soldiers expanding the opportunity for timely remedial care.

B.3. Background

The Fort Riley IACH was primarily responsible for conducting behavioral health evaluations for Soldiers assigned to the WTB. In addition, IACH developed a network of off-post behavioral healthcare facilities that provided support to WTB Soldiers.

B.3. Discussion

The on-post IACH behavioral health providers and off-post-network of behavioral health providers developed an informal group to exchange professional dialogue and communicate about Soldiers who received care outside of Fort Riley. At the time of this assessment, IACH provider staff and the group had held two meetings with approximately 30 providers in attendance. Irwin Army Community Hospital reported that all participants agreed that the concept of meeting to discuss Soldiers' treatment by the group was productive, increasing professional dialogue and facilitated communications among all providers.

B.3. Conclusion

The IACH DCCS's initiative to develop a Behavioral Health Provider group contributed to increased professional dialogue, facilitated communications between all behavioral healthcare providers, and provided access to more timely decisions and treatment options for Soldiers. These actions had a positive impact on the transition needs and goals of wounded, ill, or injured Soldiers assigned to the WTB.

B.4. Co-location of VA and MEDDAC Transition Services Enhanced VA Support to Soldiers Assigned to the WTB

Collaboration between the VA staff and the MEDDAC enhanced transition services at Fort Riley because VA offices were located in the same IACH wing as other support and transition services. This placement enabled Soldiers to receive quality and timely transition services while assigned at the WTB.

B.4. Background

The VA office location within the IACH provided the Soldiers assigned to the WTB improved access to VA services and smoother transition. WTB NCMs referred Soldiers to the VA office and provided the office with information about the Soldiers' medical conditions, treatments already provided, potential treatments required for recovery, and projected VA support and resources needed. The services available to Soldiers included Compensation and Pension Examiners, Program Support Assistance, Audiology, VA Vocational Rehabilitation Counselors, Military Service Coordinators, and Veterans Benefits Advisors.

B.4. Discussion

Co-location of the VA office enabled VA staff to attend weekly Triad of Care meetings for the Soldiers deemed high-risk. VA staff reported that their office ensure proper coordination of treatments after they left active duty by scheduling appointments for Soldiers who had recently transitioned and had been referred to the VA for follow-up care while still assigned to the WTB. The benefit was that Soldiers had quicker access to schedule VA appointments than if they had to wait until after discharge from military service.

Additionally, VA staff provided briefings and training to Triad of Care members about VA specialty programs available to Soldiers. The location of the VA office provided support to the Triad of Care and enabled Soldiers to use VA programs while at the WTB.

B.4. Conclusion

VA staff participated in Triad of Care meetings to identify high-risk Soldiers who might need additional VA support after discharge from the Army. Collaboration between VA and IACH staff provided for improved transition services to wounded, ill, or injured Soldiers, thereby improving support services while they were still in the WTB, and planned follow-on care by the VA hospital system after their separation from the Army.

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Part II - Challenges

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Observation C. Challenges for Fort Riley's Warrior Transition Battalion

We identified two challenges that needed to be addressed by the Fort Riley Wounded Warrior Battalion leadership and staff to help ensure the most successful and effective support for the care, healing, and transition of Warriors. These challenges were:

C.1. Effect of Squad Leaders and Nurse Case Managers' Workloads on Quality Care and Support

C.2. Comprehensive Transition Plans

We believe that addressing these challenges will ultimately increase the effectiveness of Fort Riley's Wounded Warrior Battalion's management and staff in providing quality and timely care and services in support of recovering Soldiers and their transitions.

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C.1. Effect of Squad Leaders and Nurse Case Managers' Workloads on Quality Care and Support

The excessive workload of the squad leaders and NCMs negatively affected the quality of support provided to WTB Soldiers.

This occurred because the extensive needs of the high risk Soldiers occupied the majority of the squad leaders' and NCMs' time and efforts.

As a result, squad leaders and NCMs were not always available or had sufficient time to assist other Soldiers with their administrative requirements and individual transition support goals.

C.1. Background

The Army established broad goals in the consolidated guidance for Soldiers assigned to the WTB. These goals were:

- to provide Soldiers with optimal medical benefit and expeditious, comprehensive personnel, and administrative processing while receiving medical care;
- to take care of Soldiers through high-quality, expert medical care;
- to administratively process Soldiers with speed and compassion during separation; and
- to assist with transitioning Soldiers' medical needs to the VA for follow-on care.

To accomplish these goals, the Army developed a Triad of Care that consisted of the platoon sergeant/squad leaders, NCMs, and PCMs working together to ensure advocacy for transitioning Soldiers' continuity of care with the intention of providing a seamless transition back to duty or to a productive civilian life.

The Triad of Care worked together as a team to collect Soldier data and information to develop a plan of care specific to each Soldier. The plan consisted of specific medical treatment, administrative requirements, and support needs of each Soldier. The following table describes the duties of the Triad of Care members:

Table 3. Triad of Care Members and Roles in Soldier Care

Triad of Care Member	Roles in Soldier Care
Nurse Case Manager (NCM)	• licensed healthcare professional works with the Soldiers in Transition throughout the medical treatment, recovery, and rehabilitation phases of care; • assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet Soldier's health needs;
Squad Leader	• NCO responsible for all that the Warrior in Transition, hereafter Soldier in Transition, does or fails to do, and works as part of the Triad providing care for the Warrior and their family; • provides direct Command and Control (C2) support for the Soldiers in Transition, and ensures the Soldier is attending necessary medical and administrative appointments; • maintains accountability of Soldiers and equipment; • links Soldiers in Transition to SFAC for administrative services and benefits; • submits requests for awards and decorations, and ensures that the Warrior's records are transferred from losing unit to gaining unit; • inspects the condition of Soldiers' billeting, clothing, and equipment; • keeps the platoon sergeant/leader informed on the squad's medical status and requirements;
Primary Care Manager (PCM)	• provides primary oversight, continuity of healthcare, and ensures the level of care provided is of the highest quality; • develops relationships with Soldiers in Transition and is the basis for successful prevention-oriented, coordinated healthcare; and • helps Soldiers in Transition benefit from consistent healthcare and improved overall health.

Source: WTU Consolidated Guidance

C.1. Discussion

At the time of our assessment, the Fort Riley WTB capacity was 207 and the population was 345 Soldiers. The Consolidated Guidance staffing ratios for the Triad of Care was:

- one Squad leader for every 10 Soldiers,
- one Primary Case Manager for every 200 Soldiers,
- one Nurse Case Manager for every 20 Soldiers,
- one Senior Nurse Case Manager for every 200 Soldiers, and
- one Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) for every 200 Soldiers.

WTB staff officers confirmed that a 1 to 10 squad leader to Soldier ratio typically worked well for Soldiers with normal administrative support needs. However, high-risk Soldiers with multiple medical issues and medications demand more of the squad leader's time. Likewise, NCMs said that they were always over their recommended and manageable caseload ratio and did not have enough time to do their jobs satisfactorily for all Soldiers assigned. NCMs attributed the excessive demand on time to the number of high-risk Soldiers that they had to manage.

Effects of Squad Leaders' Workload on Soldiers

According to the WTB Company Commanders and First Sergeants, the WTB was 13 squad leaders short. Staff and WTB Soldiers were aware that the squad leaders managed more Soldiers than the policy guidance specified and that the workload had become very demanding. The WTB Chaplain stated that the WTB was supposed to have 1 squad leader for every 10 Soldiers but that the ratio of Soldiers to squad leaders was often higher causing some squad leaders to work to exhaustion. The Fort Riley social workers commented that WTB staff experienced stress and exhaustion from their workloads. The social workers stated they expected the workload to increase. They also reported the increased complexity of the Soldiers needs being assigned to the Fort Riley WTB, and indicated that the established staffing ratios limited their flexibility in placement of Soldiers to certain companies.

Squad leaders' ratios of 1 squad leader to 10 Soldiers might not be sufficient to manage the demanding conditions of Soldiers in a WTB, especially if a disproportionate number of high-risk were assigned to one squad leader. The WTB had a population of Soldiers with many different medical conditions such as PTSD, TBI, and behavioral health issues. Furthermore, squad leaders workload increased when they assumed the duties of other squad leaders on leave or otherwise unavailable. If another WTB team member could not do his or her job then the squad leader had to do it. One squad leader reported that his caseload was 15 Soldiers, which was manageable as long as the number of high-risk Soldiers within his squad was less than 3. The ratio of Soldiers assigned to the 6 squad leaders we interviewed indicated that they collectively had 12 Soldiers over the ratio established by Army Guidance. Table 5 below shows the differences between numbers of Soldiers actually assigned to the six squad leaders we interviewed and number of Soldiers each squad leader should have in their squad per the consolidated guidance.

Table 4. Squad Leaders Soldiers Caseloads Assigned Compared to the Maximum Consolidated Guidance Requirements for the Six Squad Leaders Interviewed

Squad Leaders We Interviewed	Soldiers Actually Assigned	Per Consolidated Guidance	Difference
Squad Leader 1	9	10	-1
Squad Leader 2	10	10	0
Squad Leader 3	12	10	+2
Squad Leader 4	11	10	+1
Squad Leader 5	15	10	+5
Squad Leader 6	15	10	+5
Total Soldiers	**72**	**60**	**+12**

Source: Interviews with Squad Leaders

WTB Assigned Soldiers Comments on Squad Leaders Workload and Effect

According to the March 2011 policy, a Soldier's mandatory non-medical activities include participation in appropriate employment, educational, and internship programs (EEI) in support of their transition goals. The squad leader has the overall lead for these programs.

During our interviews, RC senior enlisted and officers stated that the excessive number of Soldiers in the unit put a strain on the squad leaders, which affected the quality of their support to the Soldiers at the WTB. Active duty sergeants through sergeant first class (E-5 through E-7) felt that there were insufficient squad leaders assigned. They claimed the stress caused one squad leader to become a patient in the WTB. Furthermore, the staffing limitations led to the inability of the WTB to effectively manage documentation essential to the transition process. The senior enlisted and officers said that the squad leaders did not have enough time to review the CTP because they were too busy. Senior enlisted and officers stated that the excessive numbers of Soldiers per squad prevented the squad leaders from assisting a number of Soldiers with their transition such as obtaining jobs or attending school. As a result, the Soldiers missed opportunities to participate in activities that could support their transition.

Effects of Nurse Case Managers' Workload on Soldiers

A majority of the NCMs interviewed reported that they were always over their policy recommended workload ratio of 1 NCM for every 20 Soldiers and had insufficient time to manage their workload. NCMs reported that the WTB, remote care, and community-based WTB were all at caseload capacity, which had pushed NCMs workload beyond a manageable ratio.

Most of the NCMs reported that their effectiveness plateaued when their workload reached 23 to 24 Soldiers. They believed that any number higher than 24 made it very difficult for them to manage the Soldier's case on an individual basis. NCMs stated that when a crisis developed with one Soldier, they were unavailable to support other Soldiers. In addition, when other NCMs were unavailable due to leave, the remaining NCMs provided coverage of their cases. This further increased the workload and demands on NCMs. Some routine administrative activities in support of Soldiers ongoing transitions had to continue regardless of the availability of assigned NCMs. One NCM mentioned that he had recently initiated close to 17 telephone consultations

instead of face-to-face meetings to help manage his case management workload. Another NCM explained that multiple factors such as mandatory meetings, training, walk-ins, and any crisis event impacted the day-to-day management of their assigned Soldier caseload.

The December 2011 CTP policy states that the Soldier, in collaboration with family members, the chain of command, Triad of Care, and other appropriate counselors, selects the transition track. The NCM as a member of the interdisciplinary team, assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet Soldiers' health needs. Within 24 hours the NCM is responsible for completing a risk assessment and an initial clinical assessment to identify the Soldier's immediate needs. Within 5 days the NCM completes a comprehensive assessment and, in collaboration with other Triad of Care members, develops a plan of care for the Soldier. Subsequently, Soldiers provided weekly input to the CTP, and NCMs monitor these inputs. NCMs commented that the CTP process would be simpler and more user-friendly if the CTP could be reviewed and signed off monthly with the exception of the those high-risk Soldiers, who usually required more frequent follow-ups. Finally, the policy states that the Soldier in conjunction with the interdisciplinary team would use the automated CTP (aCTP) system, counseling records, and Armed Forced Health Longitudinal Technology Application (AHLTA) to document aspects of his CTP. We address the CTP issues and recommendations in Observation C.2.

C.1. Conclusion

The Army established the WTB to provide support to Soldiers who require complex medical care and management support. The WTB used the Triad of Care to support the healing and transition of the wounded, ill, or injured Soldiers. As members of the Triad of Care, the squad leaders have the responsibility to be attentive to the needs of the Soldiers so that timely administrative support prevents delays in the transition process. However, the squad leaders we interviewed had especially demanding workloads that prevented them from carrying out all their responsibilities effectively. Likewise, NCMs must collaborate with Soldiers to address the effectiveness of their medical care to support successful healing. However, excessive workloads also caused the NCMs to become overburdened and placed at risk the Soldiers' transition and continuity of care.

C.1. Recommendations, Management Comments, and Our Response

C.1.1. Commander, Warrior Transition Command:

C.1.1.a. Evaluate the current and future cadre personnel requirements of the Warrior Transition Units to ensure that the staffing levels, including squad leaders and Nurse Case Managers, are appropriate to meet the mission for effective management and support of Soldiers during their healing and transition.

Office of the Surgeon General, U.S. Army Medical Command Comments

The Office of the Surgeon General, U.S. Army Medical Command concurred with our recommendation. The Surgeon General reported that the Warrior Transition Command conducts periodic reviews of WTU Table of Distribution and Allowance (TDA). The Surgeon General further explained that WTUs are structured based on forecasted WT population. The forecast models pre-deployment, theater evacuation, and post-deployment gains into the WTU population while accounting for actual deployment schedules into the future. Additionally, this forecast

process ensures WTUs are adequately designed to support WT population increases on installations, and adjust manpower to those installations where WT populations are trending downward.

The Surgeon General stated that the Warrior Transition Command received approval to continue to fill Contingency Operation for Active Duty Operational Support positions as required, and use 2-year permanent change of station orders instead of 1-year orders. Finally, they reported that the Warrior Transition Command is in the process of issuing by August 30, 2013, a revised cadre assignment policy to ensure best-qualified personnel are selected.

Our Response

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and meet the intent of the recommendation.

C.1.1.b. Conduct an analysis to determine whether the Warrior Transition Units/Warrior Transition Battalions have adequate funding and other resources to support the necessary level of WTB personnel, ongoing staff training requirements, and support services in order to maintain optimal staffing levels and ratios.

Office of the Surgeon General, U.S. Army Medical Command Comments

The Office of the Surgeon General, U.S. Army Medical Command concurred with our recommendation. The Surgeon General reported that in December 2012, the U.S. Army Manpower Analysis Agency (USAMAA) validated the WTU Ratio Determination Model for use in determining manpower requirements for all WTUs and Community Care Units. In addition, they reported that USAMAA approved the model application for 3 years. The Department of the Army issued Execution Order 079-13 on January 6, 2013, that approved maintaining the staffing levels of the WTU at current ratios. Furthermore, the Surgeon General stated that the annual analysis of the WTU funding occurs to ensure that adequate funding is available for resources and training needed by WTU support personnel.

Our Response

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and meet the intent of the recommendation.

C.2. Comprehensive Transition Plans

Soldiers and Triad of Care members were not using the CTP in the manner required by Army policy as the planning tool necessary to support the successful transition needs and goals of Soldiers. This occurred because:

- squad leaders and NCMs had excessive workloads;
- squad leaders had limited access to the CTP which prevented them from providing effective and timely input regarding the Soldier's condition;
- operation of the automated CTP (aCTP) on the Army Knowledge Online website was cumbersome, unreliable, and time consuming;
- some Soldiers were not taking advantage of the benefits of the CTP; and
- some Soldiers were not truthful or accurate with the information inputted to the CTP.

As a result, there were WTB Soldiers who were not receiving the full benefits of the CTP process as intended to help support their recovery and transition goals, thus delaying their transitions and putting at risk its success.

C.2. Background

Applicable Policies

The Office of the Surgeon General Medical Command Policy Memo, 09-011, "Comprehensive Transition Plan (CTP) Policy," March 10, 2009, stated that all Soldiers assigned or attached to a WTU would begin their comprehensive transition plans within 30 days of assignment.

In March 2011, the WTC provided guidance for the development and implementation of the Soldier's CTP and aCTP documentation tool. It stated that the primary focus of the CTP is to provide a strategic tool that supports the Soldier's goals to heal and successfully transition back to the force or to separate from the Army. Furthermore, the primary function of the WTU team is to assist in realistic goal development, provide support to the Soldier, and to validate the Soldier's CTP. In addition, the policy states that the WTU assets are available to assist the Soldiers' advancing their current military career or to prepare them for a career change while undergoing medical treatment and vocational rehabilitation. Medical needs determine the length of time the Soldiers stay in the WTU.

Subsequently, the Office of the Surgeon General issued the December 2011 CTP policy as a comprehensive update to the March 2011 CTP policy and the consolidated guidance. The December 2011 CTP policy defined the CTP as a dynamic living plan of action that focuses on the Soldier's future, is holistic, and encompasses the six domains of strength: career, physical, emotional, social, family, and spiritual. As the owner of the CTP, the Soldier is empowered to take charge of his or her own transition and is accountable for developing and achieving his or her goals.

The Army's Enterprise Portal, Army Knowledge Online

The Army's Enterprise Portal, Army Knowledge Online (AKO), is a primary component of the Army Knowledge Management (AKM) strategy and the Army Transformation. It is the single point of entry into a robust and scalable knowledge management system. AKO provides

corporate intranet services and single web portal to the United States Army. AKO provides the U.S. Army with e-mail, directory services, single sign on, blogs, file storage, instant messenger, and chat. The CTP was on the AKO during the time of our site visit in May 2011.

C.2. Discussion

The CTP is a guide that includes processes for the Soldier to use in planning for transitioning back to the Army or civilian life. Even though the CTP plan is the Soldier's plan, the Soldier's success using the plan depends on support of the WTB cadre and leadership. The commander's responsibilities include the requirements to designate an overall risk assessment and develop a mitigation plan for the Soldier. The individual assessments completed by the Triad of Care and PCM are the basis for the overall risk assessment. The commander also holds the members of the Triad of Care responsible for the Soldiers' ongoing CTP support requirements.

Soldiers were required to complete a unit orientation within 5 duty days of assignment to the Fort Riley WTB. The primary objective of the orientation was to set the Soldier's expectations and instill a transition mindset. The interdisciplinary team provided assistance by reviewing and determining the Soldier's medical condition, treatment needs and prognosis, and helped the Soldier's develop individual realistic goals. Additionally, the commander was responsible for establishing local policies and procedures to ensure that the CTP review process was effective and required tasks were completed. Ultimately, the commander was responsible for the overall WTB environment and success of the Soldiers' recovery and transition process.

Warrior Transition Battalion Staff Perception of the CTP

The WTB company commanders (CO) and first sergeants (1st SGTs) mentioned that the CTP was an effective tool for supporting Soldiers transition if properly used by the Soldiers. However, they said that using the automated aCTP on the AKO was sluggish and time-consuming. Problems with connectivity further discouraged Soldiers from wanting to use the aCTP. The COs and 1st SGTs commented that CTP access was limited to squad leaders and NCMs; platoon sergeants had visibility of the Soldiers CTP, however, because administrative access rights were unable to provide written feedback to the Soldiers information provided on the CTP.

The IACH social workers commented that Soldiers misused the CTP. Instead of focusing on the gains the Soldiers made, they used the CTP as a tool to complain about the transition process. Therefore, some Soldiers were taking their frustration out on the CTP.

Warrior Transition Unit Soldiers' Perception of the CTP

Active and RC senior enlisted and officers interviewed said that the requirement for a weekly update was not an effective use of the CTP. Other Soldiers said that not much new information was added during the weekly updates, thus reducing the value of their weekly updates. Nonetheless, when the Soldiers did not complete the CTP weekly they faced disciplinary action. Although the March 2011 CTP policy required weekly updates during the intake process, they believed the frequency should be changed to once per month thereafter.

Subsequently, the December 2011 CTP Policy changed the weekly CTP update requirement to monthly for Soldiers not deemed high risk. One officer said that the CTP had a negative effect

on his transition. He stated that he was in remote care in another state that he preferred to be in for his recovery. However, he answered the CTP honestly and the changes flagged him as high risk. He said that when his CTP status changed to high risk, he had to leave the Community Based Warrior Transition Unit (CBWTU) at his preferred location for recovery and report to Fort Riley WTB for the remainder of his recovery and transition. He said that he had been at Fort Riley for 3 months at the time of our interview. According to the Officer, the CBWTU staff encouraged the Soldiers to keep their CTPs low risk or at no-risk status to reduce the workload of the CBWTU staff.

The active duty sergeants through sergeant first class (E-5 thru E-7) in the Fort Riley WTB said that the CTPs had no effect on their transition and that completing the CTP was "just getting something done." In addition, the E-5s thru E-7s said that they received no feedback from the CTPs and no one paid any attention to their input.

The active duty and RC junior enlisted (E-1 thru E-4) Soldiers described the CTP as useless. The E-1s thru E-4s said that the experience with the CTP provided "negative feelings about their existence." They said that they, "put their heart and soul," into their CTPs for absolutely no reason. They said that the staffing levels were insufficient to read their CTP input. Furthermore, Soldiers perceived the CTP as punishment because Soldiers received counseling for not completing the CTP.

C.2. Conclusion

All Soldiers need to complete the CTP as required, but have to experience positive feedback from WTB leadership and NCMs to have the incentive to do so. Correct use of CTP processes requires a structure to support Soldiers in successfully completing their recovery and transition. Soldiers and WTB support staff have certain responsibilities for CTP input or review. In addition, WTB staff conveyed concerns about problems experienced with using the automated CTP over the AKO network. At the time of our site visit, a number of Soldiers were not receiving the full benefits the CTP process as intended to help support their recovery and transition goals.

C.2. Recommendations, Management Comments, and Our Response

C.2.1. Commander, Warrior Transition Command:

C.2.1.a. Complete the migration of the Comprehensive Transition Plan from the Army Knowledge Online to the Army Warrior Care and Transition System.

Office of the Surgeon General, U.S. Army Medical Command Comments

The Office of the Surgeon General, U.S. Army Medical Command concurred with our recommendation, stating that the migration of the CTP from Army Knowledge Online to the Army Warrior Care and Transition System (AWCTS) was completed in June 2012, in accordance with the timeline provided in Annex A to Warrior Transition Command Operational Order 11-10.

Our Response

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and meet the intent of the recommendation.

C.2.1.b. Review the Comprehensive Transition Plan policy and guidance for relevant and effective content in supporting Soldier and Family transition needs.

Office of the Surgeon General, U.S. Army Medical Command Comments

The Office of the Surgeon General, U.S. Army Medical Command concurred with our recommendation, stating that they drafted a regulation to update the CTP policy and guidance that they plan to issue by December 31, 2013.

Our Response

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and meet the intent of the recommendation.

C.2.2. Commander, Warrior Transition Battalion, assess the effectiveness of WTB leadership and cadre in actively engaging the Soldiers' CTP and encouraging Soldiers' involvement and adherence to the plan for a successful transition.

Office of the Surgeon General, U.S. Army Medical Command Comments

The Office of the Surgeon General, U.S. Army Medical Command concurred with our recommendation, stating that the Fort Riley WTB reduced the workload of the WTB Cadre to allow for effective management of all WTB Warriors, including high-risk Soldiers. In addition, the Surgeon General stated that the aCTP migration to the AWCTS improved the functionality of the CTPs. Furthermore, that the migration to the AWCTS allows for the important information to be stored in a central location for timely viewing and adjustment by all WTB stakeholders.

Our Response

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and meet the intent of the recommendation.

Observation D. Challenges for Fort Riley Irwin Army Community Hospital

We identified two challenges related to WTB Soldier medical care that needed to be addressed by Fort Riley's Irwin Army Community Hospital leadership to ensure the most successful and effective support for the care, healing, and transition of wounded, ill, and injured Soldiers. These challenges were:

D.1. Soldiers Lengthy Transition Times

D.2. Access to Behavioral Health Care Resources

We believe that addressing these challenges will ultimately increase the effectiveness of Fort Riley's Irwin Army Community Hospital in providing quality and timely care and services in support of recovering Warriors and their transitions.

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D.1. Soldiers Lengthy Transition Times

The length of time it took to complete the disability evaluation process exceeded the established timelines for Soldiers assigned to the Fort Riley WTB.

This was due in part to the lack of Fort Riley IACH personnel needed to support the high number of Medical Evaluation Board (MEB)[21] cases. Additionally, Soldiers who were undergoing their MEB were not properly educated about the MEB process and the importance of complying with their responsibilities for completion and final approval.

As a result, Soldiers had lengthy transition times with potential negative recovery effects on some Soldiers seeking to transition back to active duty or to civilian status.

D.1. Background

Disability and Integrated Disability Evaluation Systems

The Department of Defense uses the MEB and Physical Evaluation Board (PEB)[22] processes to determine the fitness for duty and disability status of Soldiers. The DoD case processing timeline goal for the MEB phase is 100 days for active component members and 140 days for those in the Reserve and National Guard component. The case processing timeline goal for the PEB is 120 days for members of all components. The VA makes a separate disability determination that drives VA disability compensation.

In November 2007, the DoD and VA initiated a joint Disability Evaluation System (DES) pilot program to analyze and significantly improve the DES timeliness, effectiveness, simplicity, and resource utilization by integrating DoD and VA processes, eliminating duplication, and improving case management practices. The DES Pilot subsequently became the Integrated DES (IDES).

The IDES features a single set of disability medical examinations intended to determine both military personnel fitness and another set of disability ratings provided by the VA. The IDES timelines required DoD and VA to completely resolve disability evaluation cases of active duty Service members within 295 days and 305 days for Reserve and National Guard service members. The time began with the referral into the IDES and ends when the Service member returns to a duty status as active duty, Reserve, or National Guard, or receives disability separation and notification of VA benefits.

The IDES was fully implemented at Fort Riley IACH in February 2010. Following our visit to Fort Riley WTB, the Under Secretary of Defense for Personnel and Readiness issued Directive-Type Memorandum (DTM) 11-015 - "Integrated Disability Evaluation System (IDES),"

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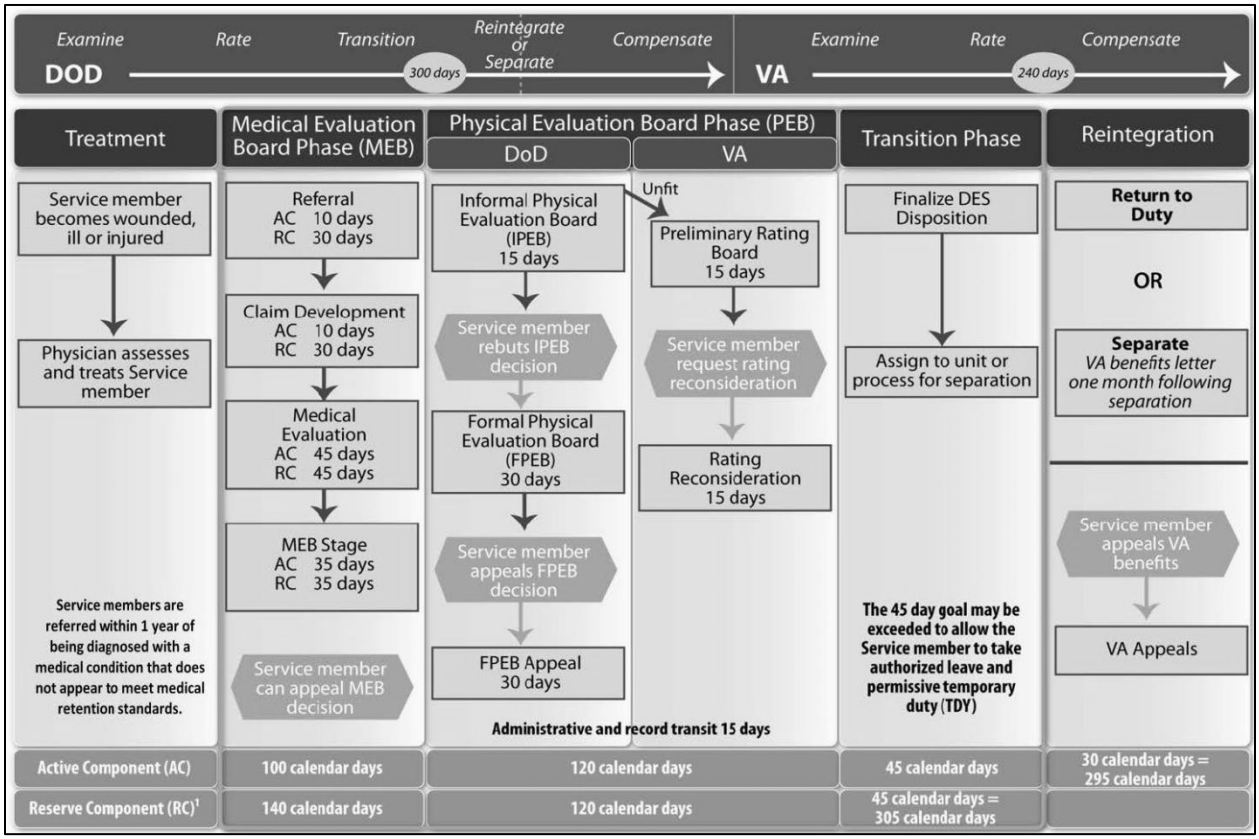
[21] The MEB is the process designed to determine whether a Soldier's long-term medical condition enables him/her to continue to meet medical retention standards. The MEB is an informal board process because, by itself, it does not drive any personnel actions.

[22] The Physical Evaluation Board formally determines fitness for continued service and eligibility for disability compensation.

December 19, 2011. This DTM establishes policy, assigns responsibilities, and prescribes procedures for the IDES process.

The MEB and the PEB are the two main phases in the IDES processes. The MEB phase begins at the point of referral into the IDES and includes all activities up to the transfer of the completed MEB case file to the PEB. The PEB reviews a Soldier's medical and duty performance evidence to make a determination of fitness to continued military service. See figure 3 below for the full IDES process timelines.

Figure 3. Integrated Disability Evaluation System Timeline



Source: DTM 11-015 dated December 19, 2011

A crucial component of the MEB and PEB is the Narrative Summary (NARSUM). The NARSUM documents the history of the Soldier's illness, objective findings based on examinations, results of radiology and laboratory tests, reports of consultations, response to therapy, and subjective medical staff conclusions with justifying rationale. The NARSUM seeks to establish a correlation between the Soldier's medical defects and physical capabilities. Therefore, NARSUMs must be timely and accurate in order to provide members of the MEB and PEB the best information to make a decision regarding how long the disability will persist because the persistence of the disability determines the Soldiers' fitness for duty. Physical examinations[23] and NARSUMs are valid for 6 months only, and should be used within 6 months

[23] AR 40–400 • 27 January 2010 par 7-11(a)

to provide a timely assessment of the Soldiers' medical defects and physical capabilities. See Appendix F for more information on the MEB process and the purpose of the NARSUM.

The Physical Evaluation Board Liaison Officer (PEBLO) is the subject matter expert who provides significant support to Soldiers at the Fort Riley WTB. PEBLOs establish and maintain communications between the Military Service Coordinators (MSC) and medical providers, create reports, and inform the MEDDAC Command Staff and Division Surgeon's office on the progress of cases through the IDES. PEBLOs track and provide information to Soldiers about their progress on treatment and evaluation through the DES process.

D.1. Discussion

Fort Riley WTB Soldiers' disability determinations took an average of 540 days to process through the IDES, which exceeded the timelines of 295 days and 305 days for active and Reserve Soldiers respectively.

MEB delays reportedly occurred because of the time required to retrieve medical and administrative documents from other units and Soldiers were missing and rescheduling medical appointments. Furthermore, Soldiers had to redo medical and behavioral health appointments because their NARSUMs were over 6 months old, and no longer valid. In addition, IACH medical and support staff explained that the lengthy processing time was also due to insufficient staffing levels to support the high numbers of Soldiers undergoing MEBs. At the time of our assessment, approximately 12,000[24] active duty Soldiers were in the process of undergoing MEBs, with over 100 MEB cases on average added weekly. These numbers did not include the Reserve Component Soldiers in the IDES process at Fort Riley.

Junior enlisted (E-1 thru E-4) Soldiers provided some examples of the delays with the MEB process.

- One Soldier said it took one month to gather medical records for compilation into one record.
- Another Soldier said it took over six months to obtain his records.
- A Soldier said it took five months to process his NARSUM.
- One Soldier said his MEB was already in its seventh month. He added that an error with the NARSUM further delayed the MEB by five months to correct the NARSUM error.

The Family Advocate and the Warrior Transition Command Veteran's Advocate said that psychological NARSUMS usually took longer because of the limited availability of IACH Behavioral Health providers. In addition, delays also occurred in receiving Soldiers specialty medical referral reports from off post providers. PEBLOs recommended caseload was 20 Soldiers; however, at the time of our visit in May 2011, PEBLOs had caseloads of 95 Soldiers each. The PEBLOs said that they received 75 referrals a month but had the ability to complete

[24] The 12,000 Active Duty Service members in the MEB included Soldiers assigned to the WTU and Soldiers going through the process while still assigned to their units.

only 25. PEBLOs attributed lengthy transition times to the staffing shortages in Mental Health and other clinical staff supporting the MEB and PEB processes.

Our team determined that the MEB phase for Soldiers assigned to the Fort Riley WTB exceeded the established 100-day timeline for active Components and 140 days for Reserve Components. IACH medical providers, administrative support staff, and Soldiers agreed that the lengthy process had a negative effect on WTB Soldiers' transition plans and goals. One Soldier said that his MEB had taken so long that he moved his family without military assistance or reimbursement because he did not want them to wait at Fort Riley until the end of his medical board.

Similar to the active duty officers and senior enlisted WTB-assigned Soldiers, the WTB-assigned RC officers and senior enlisted Soldiers described the process as excessive because it took too long for Soldiers to process though the MEB and get their disability results. Soldiers could not effectively determine their transition date from the Army to apply for jobs or register for educational opportunities to meet their transition goals and needs. Soldiers who wanted to attend college could not register for school and had concerns that they would have to wait until subsequent semesters. Moreover, one group of healthcare providers stated that the longer Soldiers stayed in the WTB, the more new or aggravating conditions they reported. In addition, another group of providers commented that some WTB Soldiers stayed longer at the WTB because the Soldiers reported new medical problems as severe, that the providers later determined as minor and did not require assignment to the WTB for case management services.

D.1. Conclusion

We acknowledge the ongoing work by DoD, VA, and staff to address the multitude of systemic issues and concerns that continue to affect the phases of the IDES process. However, the prolonged IDES process appeared to contribute to frustrations and complaints among Soldiers which negatively impacted the Soldiers and their families as they prepare to transition back to active duty or to civilian life.

D.1. Recommendations, Management Comments, and Our Response

D.1.1. Commander, Western Regional Medical Command track each phase of the Integrated Disability Evaluation System (IDES) process to identify and resolve the barriers to timely IDES completion for Soldiers assigned or attached to WTBs.

The Office of the Surgeon General, U.S. Army Medical Command Comments

The Office of the Surgeon General, U.S. Army Medical Command concurred with our recommendation, stating that in June 2012, the Western Region Medical Command (WRMC) developed and staffed a new IDES section within the Warrior Transition Office (WTO) to identify, monitor, and analyze trends and conditions affecting timely and efficient disability processing for WTB Soldiers. In addition, they reported that the Veterans Tracking Application (VTA) was established in February 2012 as the system of record for the selected measures. The VTA receive updates from IDES stakeholders such as PEBLO, PEB, and the VA Disability Evaluation System Rating Activity Sites (DRAS). From these updates, the WTO can track the progress of the Soldiers through the IDES processes.

To improve the timeliness, the WRMC WTO began to hold monthly telephone meetings in March 2013 with the military treatment facilities to discuss MEB cases that exceed the completion date by 150 days. Again in March 2013, the WRMC revised the threshold date for MEB case review from 150 days to 100 days.

Our Response

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and meet the intent of the recommendation.

D.1.2. Commander, Irwin Army Community Hospital:

> **D.1.2.a. Identify obstacles within the Soldiers' MEB referral, claim development, medical evaluation, and MEB processing phases that inhibit prompt MEB completion, and provide sufficient staff support for Physical Evaluation Board Liaison Officers and ensure that staff to Soldier ratio is sufficient to ensure timely processing of MEB packages.**

The Office of the Surgeon General, U.S. Army Medical Command Comments

The Office of the Surgeon General, U.S. Army Medical Command concurred with our recommendation, stating that the Fort Riley staff supporting the MEB phase increased to allow IACH to meet the MEDCOM IDES timeline of 100 days for completing the Soldiers' MEBs. The Surgeon General stated that in January 2013, the IACH met and continue to meet the MEDCOM timeline goals for MEBs. To meet the timeline goals, Fort Riley began using the Strategic Management System (SMS) for all IDES data collecting and reporting. The SMS data comes from VTA and eMEB as weekly updates that IDES staff use for analysis of MEB progress.

Our Response

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and meet the intent of the recommendation.

> **D.1.2.b. Educate Soldiers and their families on how to execute the IDES process to include a realistic timeline for what the Soldier can expect once the process begins.**

The Office of the Surgeon General, U.S. Army Medical Command Comments

The Office of the Surgeon General, U.S. Army Medical Command concurred with our recommendation, stating that Soldiers receive education from the beginning and thoughtout the IDES process. The Surgeon General stated that this occurs from initiation into the IDES because key members of the IDES process host a IDES welcome brief that all Soldiers must attend. They stated that the welcome brief provides an overview of the IDES process. Later, Soldiers receive continual IDES process education when the Soldiers meet with the PEBLO, MSC, VA provider, and the NARSUM writer.

Our Response

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and meet the intent of the recommendation.

D.1.2.c. Develop a mechanism whereby a Soldier can track and be informed of his or her status in the IDES process.

The Office of the Surgeon General, U.S. Army Medical Command Comments

The Office of the Surgeon General, U.S. Army Medical Command concurred with our recommendation, stating that the PEBLO is available for questions about the Soldiers IDES process and that the "My MEB" on the AKO provides Soldiers access to the status of their IDES process. The PEBLOs provide weekly updates to soldiers on the status of their cases. In addition, the Surgeon General stated that the PEBLOs meet monthly with Soldiers units to provide IDES status updates. "My MEB" information comes from the eMEB and the VTA.

Our Response

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and meet the intent of the recommendation.

D.2. Access to Behavioral Health Care Resources

Fort Riley WTB Soldiers were unable to schedule and receive timely behavioral health services at IACH to meet their health needs and to support the medical board process.

This occurred because there were not enough behavioral health and supporting behavioral health services to support the demand.

As a result, the Soldiers and their families did not receive timely care to address their needs to heal and transition back to the Army or to civilian life. This extended their stay beyond established standards and could negatively impact Soldiers' medical recovery.

D.2. Background

According to the Assistant Secretary of Defense for Health Affairs, (TRICARE[25] Policy for Access to Care) dated February 23, 2011, initial treatment to evaluate new or recurrent behavioral health needs involves an evaluation by a provider who is professionally capable or specifically privileged to perform behavioral health assessments. Requests for medical appointments regarding a new behavioral health condition or exacerbation of a previously diagnosed condition, when not urgent, are defined as routine care, and a medical appointment should be offered within 7 calendar days and within 30 minutes travel time. If the behavioral health condition is urgent, the appointment must be within 24 hours and within 30 minutes travel time. Any additional required behavioral health care is considered "specialty" care and appointments are supposed to be provided within 28 days.

The Consolidated Guidance states that the Office of the Surgeon General and U.S. Army Medical Command will maximize capacity by:

- increasing staff at behavioral health care capacity at military treatment facilities;
- temporarily shifting resources and effectively utilizing a combination of resources to improve access to health care and behavioral health care; and
- reducing the administrative time that Soldiers spend in WTUs.

D.2. Discussion

Fort Riley IACH had available limited off-post TRICARE providers to augment behavioral health treatment support to Soldiers assigned to the Fort Riley WTB. Furthermore, the IACH had designated the MTF as the primary source for behavioral health treatment appointments for Soldiers. In addition, IACH used the behavioral health staff extensively for completing NARSUMs and fit-for-duty evaluations, which reduced the number of behavioral medical care appointments available to Soldiers.

[25] TRICARE is managed by TRICARE Management Activity, a field activity under the policy guidance and direction of the Assistant Secretary of Defense (Health Affairs) (ASD[HA]). The TMA manages the TRICARE budget, executes TRICARE policies and oversees the entire TRICARE health program.

Adequacy of the Use of the Behavioral Health Team and Impact on the Availability of Appointments

IACH used the Behavioral Health Team to complete the medical board backlog of NARSUMs and fit-for-duty evaluations. Within an 8-month period (September 2010 to May 2011), the outstanding MEB evaluations caseload increased from approximately 200 to 1,000. In addition, all Soldiers going through the disability evaluation process required a behavioral health evaluation, which took approximately two hours to complete. Behavioral health providers had to conduct 100 percent evaluations of Soldiers going through the IDES process, as well as medically treat Soldiers with PTSD, TBI, and other psychiatric illnesses.

Psychiatric NARSUMS Impacted by Time

The physical portions of the NARSUM were timely, but delays frequently occurred in completing the psychiatric portion of the NARSUM. In some cases, the Psychiatric NARSUMS took approximately 3 to 4 months on average to complete and would extend for as much as 8 months. Because the NARSUMs and behavioral health evaluations were only valid for 6 months, Soldiers had to redo behavioral health appointments for expired NARSUMs and evaluations. Whenever a completed NARSUM needed revision, Soldiers were at risk of having to re-accomplish multiple behavioral health appointments and then wait another 3 to 4 months for their completed NARSUM before they could continue their transition. The waiting period to complete the MEB phase of the IDES therefore increased for Soldiers due to the delay in waiting to complete the psychiatric portion of their NARSUMS.

Quality of Life and Transition Times Negatively Affected by Lack of Behavioral Health Appointments.

The Army Wounded Warrior Program Family Advocates stated that Fort Riley IACH needed more behavioral health assets to help the Soldiers and their families. Because Fort Riley IACH had limited behavioral healthcare resources available in the local civilian community, some Soldiers had to travel to locations such as Lincoln, Nebraska; Washington D.C.; or San Antonio, Texas, for access to certain behavioral health resources. These locations were beyond the 30-minute drive time mandated in the TRICARE access to care policy because the nearest location, Lincoln, Nebraska, was 152 miles from Fort Riley. It could take months to get an appointment at the Fort Riley IACH because IACH had limited local behavioral health resources. TRICARE access to care policy required behavioral healthcare appointments within 28 days for non-urgent care and 24 hours for urgent care. This standard was not consistently being met.

Additionally, the advocates commented that with the lack of behavioral healthcare resources and meaningful activities, Soldiers were potentially at risk for discipline problems, high-risk behaviors, such as “four wheeling,” suicides, increased drinking, and driving while intoxicated. These limited resources also put a strain on marriages and family well-being.

Soldiers often defaulted to walk-in appointments when they needed prompt behavioral health treatment. However, these walk-in appointments disrupted their continuity of care because Soldiers had to explain repeatedly their history every time they saw a different behavioral health provider. The Soldiers said that repeating the same stories of their trauma was stressful, and that they had to rebuild a trusting relationship every time they saw a new behavioral health provider. Furthermore, the involvement of multiple behavioral healthcare providers required additional

coordination among behavioral health providers to agree on the correct treatment plan for the Soldiers and ensure that the plan was accurately reflected in the Soldiers NARSUM.

D.2. Conclusion

Behavioral healthcare resources at Fort Riley IACH were insufficient to meet the TRICARE access to care standards and Soldiers' needs. The IACH Behavioral Healthcare team could not adequately support medical boards, and provide behavioral health care appointments to Soldiers and their families. IACH leadership implemented several noteworthy practices which included coordinating behavioral healthcare with community behavioral health providers (See Observation B.3), and sending Soldiers to other military treatment facilities for behavioral healthcare. Despite these innovative actions, behavioral health capacity remained inadequate. As a result, Soldiers and their families were at risk of not receiving timely, comprehensive behavioral healthcare, which adversely affected quality of life and well-being for them and their families, as well as impeded Soldier healing and delayed transition.

D.2. Recommendations, Management Comments, and Our Responses

D.2.1. Commander, United States Army Medical Command develop options for increasing the number of behavioral health personnel at Fort Riley Irwin Army Community Hospital to support the numbers of Soldiers requiring such care and to accelerate MEB processing.

The Office of the Surgeon General, U.S. Army Medical Command Comments

The Office of the Surgeon General, U.S. Army Medical Command concurred with our recommendation, and noted that IACH is currently meeting the MEDCOM 100-day standard for MEBs. The Surgeon General further stated that given the announced reductions in force structure at Fort Riley, no further increase to the number of Behavioral Health Providers is warranted. In addition, the scheduled reduction of the WTB population from 400 to 270 in October 2013 will alleviate the need for an increase in the Behavioral Health staff.

Our Response

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and meet the intent of the recommendation.

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Appendix A. Scope, Methodology, and Acronyms

We announced and began this assessment on April 16, 2010. Based on our objectives, we planned and performed the assessment to obtain sufficient evidence to provide a reasonable basis for our observations, conclusions, and recommendations. The team used professional judgment to develop reportable themes drawn from multiple sources, to include interviews with individuals and groups of individuals, observations at visited sites, and reviews of documents.

We visited the Medical Department Activity (MEDDAC) and the Fort Riley Warrior Transition Battalion (WTB) located at Fort Riley, Kansas, from May 10- 20, 2011. During our site visit to that location, we observed battalion operations and formations; viewed living quarters; campus facilities; and selected operations at the medical facility; and examined pertinent documentation. We also conducted meetings and interviews – ranging from unit commanders, staff officers, and WTB staff, to civilian staff and contractors – as shown below:

- MEDDAC Commander and Sergeant Major
- Deputy Commander for Clinical Services
- Deputy Commander for Administration
- Deputy Commander Health Services/Senior Nurse
- WTB Commander, Sergeant Major, and Executive Officer
- WTB Operations and Personnel Officers
- WTB Surgeon
- WTB Pharmacist
- WTB Chaplain
- WTB Company Commanders
- WTB First Sergeants
- WTB Squad Leaders
- Primary Care Managers
- Nurse Case Managers
- Behavioral Health Clinical Psychologists
- Behavioral Health Licensed Clinical Social Workers
- Occupational Therapists
- Soldier and Family Assistance Center Director
- Physical Evaluation Board Liaison Officer (PEBLO)
- Ombudsman
- Soldier Family Advocate
- Family Member of Recovering Service Member

Further, we performed interviews with WTB recovering Soldiers, to include 48 individual interviews, and 6 group interviews by rank and component. The 6 groups totaled 91 Soldiers that consisted of 45 Active Duty and 46 National Guard/Reserves. Table 1 below shows the six groups divided by Army Component, rank, and grade and the number interviewed.

Table 1. The Army Component Categorization of the Group Soldiers Interviews Conducted at Fort Riley between May 10, 2011 and May 20, 2011

Group Number	Army Component	Rank and Grade	Number Interviewed
Group 1	Active Duty	E1- E4 (Private through Specialist)	20
Group 2	Active Duty	E5- E7 (Sergeant through Sergeant First Class)	20
Group 3	Active Duty	E8- O4 (Master Sergeant/First Sergeant through Lieutenant Colonel)	5
Group 4	National Guard and Reserves	E1- E4 (Private through Specialist)	20
Group 5	National Guard and Reserves	E5- E7 (Sergeant through Sergeant First Class)	18
Group 6	National Guard and Reserves	E8- O5 (Master Sergeant/First Sergeant through Lieutenant Colonel)	8

Source: Obtained from the SPO DoD OIG Interviewee List

We prepared standardized sets of questions used during individual and group sessions, which we tailored to the type or group of personnel interviewed. Those interviews primarily included, but were not limited to, recovering Soldiers and members of the Triad of Care – primary care managers, nurse case managers, and WTB squad leaders. The standardized interview questions for these groups included topics such as access to care, use of Comprehensive Transition Plans, responsibilities for Triad of Care members, working relationships amongst the Triad of Care members, and discipline issues within the WTB.

Use of Technical Assistance and Computer-Processed Data

We did not use computer-processed data to perform this assessment. However, analysts from the DoD Office of the Inspector General, Deputy Inspector General for Audit, Quantitative Methods and Analysis Division, used a simple random sample approach to determine the number of Soldiers we should interview at the Fort Riley WTB to obtain a representative sample. The use of a random sample was to avoid introducing any biases that could occur by selecting interviewees non-statistically.

The analysts used a list of Soldiers identified by name and WTB company assignment (Alpha Company, Bravo Company, and Headquarters Company), which we obtained from the Fort Riley WTB. As of April 21, 2011, the total population of Soldiers at the Fort Riley WTB was 308 Soldiers, comprising the total population from which we drew our random sample.

The analysts used a program called the Statistical Analysis System and its internal random number generator to assign random values to each individual, then sorted all 308 Soldiers into random number sequence. Using this method, the analysts calculated a sample size of 56 Soldiers for individual interviews. We based the sample size on a 90 percent confidence level, a planned margin of error of 10 percent, and the statistically conservative assumption of a 50 percent error rate. First, the team used this approach to determine whether those most impacted by their assignment to the WTB identified reportable themes (noteworthy practices, good news, issues, concerns, and challenges): the Soldiers.

We provided the list of 65 Soldiers to interview from our randomly generated sample to the Fort Riley WTB. We advised the WTB to fill the interview slots with the Soldiers indicated. If an individual Soldier selected for was not available, we provided a list of 15 alternates as replacements in case the originally selected were not available for interview. The total Soldiers identified for interviews were 80. We further advised the Fort Riley WTB that a justification must be provided for any individuals in that sequence that were unable to attend an interview for mitigating reasons such as convalescent leave, annual leave, medical appointments, physical impairments, or logistical constraints.

We interviewed 48 Soldiers of which 42 Soldiers were from the primary list and six were from the alternate list. The Fort Riley WTB provided an acceptable excuse for all the Soldiers who were unavailable for the interviews. The acceptable excuses included At Remote Care, Regular Leave, Maternity and Paternity Leave, Terminal Leave, Permanent Change of Station, and Transferred to In-Patient Care. We believe that the information obtained from the 48 individuals selected as part of our original random sample, as well as the six groups of Active Duty and National Guard/Reserve Soldiers provided a reasonable indication of the views of the total population.

We met and interviewed others – ranging from unit commanders, staff officers, and WTB staff, to civilian staff and contractors – to corroborate the identified themes or to identify other reportable themes not readily known to the Soldiers.

Acronym List

The following are acronyms used in this report.

1st ID	1st Infantry Division
AW2	Army Wounded Warrior Program
ACAP	Army Career and Alumni Program
ACS	Army Community Service
aCTP	Automated Comprehensive Transition Plan
AHLTA	Armed Forced Health Longitudinal Technology Application
AKM	Army Knowledge Management
AKO	Army Knowledge Online
ALTRACT	All Army Activities
AWCTS	Army Warrior Care and Transition System
BH	Behavioral Health
BRAC	Base Realignment and Closure
C2	Command and Control
CAC	Common Access Cards
CBWTU	Community Based Warrior Transition Unit
CER	Career and Education Readiness
CG	Commanding General
CHTW	Coming Home to Work
CM	Case Management
CO-ADOS	Contingency Operations Active Duty for Operational Support
CONUS	Continental United States
COTA	Certified Occupational Therapy Assistant
CSF	Comprehensive Soldier Fitness
CSW	Clinical Social Worker
CTP	Comprehensive Transition Plan
CTP-G	Comprehensive Transition Plan - Guidance
CWO2	Chief Warrant Officer Two
CYS/CYSS	Child, Youth, and School Services
DES	Disability Evaluation System
DCCS	Deputy Commander for Clinical Services
DODI	Department of Defense Instruction
DOD IG	Department of Defense Office of the Inspector General
DTM	Directive-Type Memorandum
DVA	Department of Veterans Affairs
DVBIC	Defense and Veterans Brain Injury Center
E2I	Education and Employment Initiative
EEI	Employment, Educational, and Internship Programs
EFMP	Exceptional Family Member Program
ERS	Evaluation Reporting System
EXORD	Execution Order
FRAGO	Fragmentary Order
FTR	Focused Transition Review

GME	Graduate Medical Education
HHC	Headquarters and Headquarters Company
IACH	Irwin Army Community Hospital
IDES	Integrated Disability Evaluation System
JER	Joint Ethics Regulation
LCSW	Licensed Clinical Social Worker
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
MEB	Medical Evaluation Board
MEDCOM	The United States Army Medical Command
MEDDAC	Medical Department Activity
MSC	Military Service Coordinator
mTBI	Mild Traumatic Brain Injury
MTF	Military Treatment Facility
NARSUM	Narrative Summary
NCM	Nurse Case Managers
NCO	Non-Commissioned Officer
NJP	Non-Judicial Punishment
OCO	Overseas Contingency Operations
OPORD	Operational Order
OTR	Occupational Therapist Registered
OTSG	Office of the Surgeon General
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OWF	Operation WARFIGHTER
PA	Physician Assistant
PCM	Primary Care Manager
PCS	Permanent Change of Station
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
PMART	Pharmacy Medication Analysis & Reporting Tool
PT	Physical Therapist
PTA	Physical Therapy Assistant
PTSD	Post-Traumatic Stress Disorder
RC	Reserve Component
SFAC	Soldier and Family Assistant Center
SL	Squad Leader
SOPs	Standard Operation Procedures
SUN	Spouses Understanding Needs
TBI	Traumatic Brain Injury
TCS	Temporary Change of Station
TDRL	Temporary Disability Retired List
TOL	Triad of Leadership
TRICARE	Tri-Service Medical Care
TSGLI	Traumatic Servicemember’s Group Life Insurance
UCMJ	Uniform Code of Military Justice

VA	Department of Veterans Affairs
VR&E	Vocational Rehabilitation and Employment
WCTP	Warrior Care and Transition Program
WT	Warrior in Transition
WTB	Warrior Transition Battalion
WTC	Warrior Transition Command
WTU	Warrior Transition Units
WRMC	Western Regional Medical Command

Appendix B. Summary of Prior Coverage

Several reports were issued during the past 6 years about Department of Defense and Department of Veterans Affairs' health care services and management, disability programs, and benefits. The Government Accountability Office (GAO), the Department of Defense Inspector General (DOD IG), and the Naval Audit Service have issued 28 reports relevant to DoD Warrior Care and Transition Programs.

Unrestricted GAO reports can be accessed over the Internet at http://www.gao.gov. Unrestricted DOD IG reports can be accessed at http://www.dodig.mil/PUBS/index.html. Naval Audit Service reports are not available over the Internet.

GAO

GAO Report No. GAO-13-5, "Recovering Servicemembers and Veterans, Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits," November 2012

GAO Report No. GAO-12-676, "Military Disability System: Improved Monitoring Needed to Better Track and Manage Performance," August 28, 2012

GAO Report No. GAO-12-718T, "Military Disability System: Preliminary Observations on Efforts to Improve Performance," May 23, 2012

GAO Report No. GAO-12-27R, "Department of Defense: Use of Neurocognitive Assessment Tools in Post-Deployment Identification of Mild Traumatic Brain Injury," October 24, 2011

GAO Report No. GAO-12-129T, "DOD and VA Health Care: Action Needed to Strengthen Integration across Care Coordination and Case Management Programs," October 6, 2011

GAO Report No. GAO-11-551, "Defense Health Care: DOD Lacks Assurance that Selected Reserve Members Are Informed about TRICARE Reserve Select," June 3, 2011

GAO Report No. GAO-11-572T, "Federal Recovery Coordination Program: Enrollment, Staffing, and Care Coordination Pose Significant Challenges," May 13, 2011

GAO Report No. GAO-11-633T, "Military and Veterans Disability System: Worldwide Deployment of Integrated System Warrants Careful Monitoring," May 4, 2011

GAO Report No. GAO-11-32, "VA Health Care: VA Spends Millions on Post-Traumatic Stress Disorder Research and Incorporates Research Outcomes into Guidelines and Policy for Post-Traumatic Stress Disorder Services," January 24, 2011

GAO Report No. GAO-11-69, "Military and Veterans Disability System: Pilot Has Achieved Some Goals, but Further Planning and Monitoring Needed," December 6, 2010

GAO Report No. GAO-09-357, “Army Health Care: Progress Made in Staffing and Monitoring Units that Provide Outpatient Case Management, but Additional Steps Needed,” April 20, 2009

GAO Report No. GAO-09-31, “Defense Health Care: Additional Efforts Needed to Ensure Compliance with Personality Disorder Separation Requirements,” October 31, 2008

GAO Report No. GAO-08-635, “Federal Disability Programs: More Strategic Coordination Could Help Overcome Challenges to Needed Transformation,” May 20, 2008

GAO Report No. GAO-08-615, “DOD Health Care: Mental Health and Traumatic Brain Injury Screening Efforts Implemented, but Consistent Pre-Deployment Medical Record Review Policies Needed,” May 30, 2008

GAO Report No. GAO-08-514T, “DOD and VA: Preliminary Observations on Efforts to Improve Care Management and Disability Evaluations for Servicemembers,” February 27, 2008

GAO Report No. GAO-07-1256T, “DOD and VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers,” September 26, 2007

GAO Report No. GAO-06-397, “Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers,” May 11, 2006

DOD

Department of Defense Recovering Warrior Task Force, 2011-2012 Annual Report, August 31, 2012

Department of Defense Recovering Warrior Task Force, 2010-2011 Annual Report, September 2, 2011

DOD IG

DOD IG Report No. DODIG-2012-120, “Assessment of DoD Wounded Warrior Matters – Wounded Warrior Battalion – West Headquarters and Southern California Units,” August 22, 2012

DOD IG Report No. DODIG-2012-067, “Assessment of DoD Wounded Warrior Matters – Camp Lejeune,” March 30, 2012

DOD IG Report No. SPO-2011-010, “Assessment of DOD Wounded Warrior Matters – Fort Drum” September 30, 2011

DOD IG Report No. SPO-2011-004, “Assessment of DOD Wounded Warrior Matters – Fort Sam Houston,” March 17, 2011

DOD IG Report No. IE-2008-005, "DoD/VA Care Transition Process for Service Members Injured in Operation Iraqi Freedom/Operation Enduring Freedom," June 12, 2008

DOD IG Report No. IE-2008-003, "Observations and Critique of the DoD Task Force on Mental Health," April 15, 2008

Army

Army Audit Report No. A-2011-0008-IEM, "Army Warrior Care and Transition Program," October 21, 2010

Navy

Naval Audit Service Report No. N2009-0046, "Marine Corps Transition Assistance Management Program – Preseparation Counseling Requirement," September 15, 2009

Naval Audit Service Report No. N2009-0009, "Department of the Navy Fisher Houses," November 4, 2008

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Appendix C. Reporting Other Issues

We performed the Assessment of DoD Wounded Warrior Matters at four Army WTB locations and two Marine Corps Wounded Warrior Battalion (WWBn) locations and reported on each location separately. This assessment report focused on whether the programs for the care, management, and transition of Warriors in Transition at the Fort Riley, Kansas, WTB were managed effectively and efficiently.

Additionally, in the future we plan to report on issues, concerns, and challenges that were common among the six sites we visited, and identified as systemic issues. These reports will be provided to appropriate organizations to provide information on or identify corrective actions addressing those issues, concerns, and challenges. Those organizations may include but are not limited to the Under Secretary of Defense for Personnel and Readiness; the Assistant Secretary of Defense for Health Affairs; the U.S. Army Medical Department, Office of the Surgeon General; the U.S. Army Medical Command, Warrior Transition Command; and others as required.

This appendix captures issues, concerns, and challenges we identified that may be included in future reports. Refer to the table below for some potential report topics.

Table 2. Potential Report Topics

Issue, Concerns, and Challenges	Report Reference(s)
Selection and Training of Leaders and Cadre of Warrior Transition Units	N/A
Medication Management	B.2., pages 26-29
Assessment of Navy and Air Force Wounded Warrior Programs	N/A
Management of National Guard and Reserve Recovering Service Members Healthcare Delivery	B.1., pages 23-25
Timely Access to Specialty Medical Care	D.2., pages 55-57
Service-level Management of the Integrated Disability Evaluation System (IDES)	D.1., pages 49-54

Source: Results of Assessments of the DoD Wounded Warrior Matters

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Appendix D. Army Guidance for Warrior Transition Units

Army guidance for the care and management of Warriors is contained in the "Warrior Transition Unit Consolidated Guidance (Administrative)," March 20, 2009 (hereafter, "Consolidated Guidance"). It was revised in March 20, 2009 to update policies and guidance for the care and management of Warriors. According to the Consolidated Guidance, a Warrior is a Soldier assigned or attached to a WTU whose primary mission is to heal.

The Consolidated Guidance addresses specific policy guidance regarding assignment or attachment to a WTU, the process for the issuance of orders to Soldiers, and other administrative procedures for Soldiers under consideration for assignment or attachment to a WTU. The publication also summarizes existing personnel policies for family escort, non-medical attendant, housing prioritization, leave, and other administrative procedures for Soldiers assigned or attached to a WTU. Further, it provides information on the Physical Disability Evaluation System for Soldiers processing through this system.

Pertinent Federal statutes, regulations, and other standards governing these programs and services are cited throughout the Consolidated Guidance and are collated in a reference section. The document also states that, previously, there was no overarching Army collective or regulatory administrative guidance for WTUs.

The authorities for establishing the WTUs are:

- Department of the Army EXORD [Execute Order] 118-07 Healing Warriors, June 21, 2007
- Department of the Army FRAGO [Fragmentary Order] 1 to EXORD 118-07 Healing Warriors, August 16, 2007.
- Department of the Army FRAGO 2 to EXORD 118-07 Healing Warriors, December 14, 2007.
- Department of the Army FRAGO 3 to EXORD 118-07 Healing Warriors, July 1, 2008.

The overview of the WTU program is stated as:

- Vision – to create an institutionalized, Soldier-centered WTU program that ensures standardization, quality outcomes, and consistency with seamless transitions of the Soldier's medical and duty status from points of entry to disposition.
- Goal – to expeditiously and effectively evaluate, treat, return to duty, and/or administratively process out of the Army, and refer to the appropriate follow-on healthcare system, Soldiers with medical conditions.
- Intent – to provide Soldiers with optimal medical benefit, expeditious and comprehensive personnel and administrative processing, while receiving medical care. The Army will take care of its Soldiers through high quality, expert medical care. For those who will leave the Army, the Army will administratively process them with speed and compassion. The Army will assist with transitioning Soldiers' medical needs to the Department of Veterans Affairs for follow-on care.

The objectives of the WTU program are stated as:

- "Address and ensure resolution on all aspects of personnel administration and processing for the WT [a Warrior] from points of entry through disposition, to include processing through the Physical Disability Evaluation System (PDES). Final disposition occurs when the WT is determined/found medically cleared for duty or the PDES process is complete, including appeals."
- "Address and ensure resolution on the administrative aspect of medical management for the WT, including Tri-Service Medical Care (TRICARE) and/or Veterans Health Administration follow on medical care."
- "Address and ensure resolution on command and control (C2), including logistical support, for the WT assigned or attached to garrison units, Medical Treatment Facilities (MTF), Warrior Transition Units (WTU), and Community-Based Warrior Transition Unit (CBWTU)."[26]
- "Address and ensure resolution on the accountability and tracking of the WT in real time as he/she progresses through the WT process and if necessary, the PDES process."

The Mission Essential Task List of the WTU program states that the Army will–

- "Provide Command/Control and Administrative Support (including pay) trained to focus on special needs of WT Soldiers."
- "Provide high quality, expert medical care, and case management support - Primary Care Provider, Case Manager, Behavioral Health, Specialty Providers."
- "Administratively process with speed and compassion those who will leave the Army."
- "Facilitate transition of separating and REFRAD'ing [Release From Active Duty] Soldiers to the VHA [Veterans Health Administration] or TRICARE for follow-on care."

The WTU concept of operations is stated as:

- "Provide Soldiers high-quality living conditions."
- "Prevent unnecessary procedural delays."
- "Establish conditions that facilitate Soldier's healing process physically, mentally, and spiritually."
- "Provide a Triad of Warrior Support that consist of Platoon Sergeant/Squad Leader, Case Manager (CM), and Primary Care Manager (PCM), working together to ensure advocacy for WT Soldiers, continuity of care and a seamless transition in the force or return to a productive civilian life."

[26] Community-Based WTUs are primarily for Reserve Component Soldiers. Community-Based WTU is a program that allows Warriors to live at home and perform duty at a location near home while receiving medical care from the Tricare network, the Department of Veterans Affairs, or Military Treatment Facility providers in or near the Soldier's community.

Appendix E. Office of the Surgeon General Policy for the Comprehensive Transition Plan

The Army Surgeon General is also the Commanding General of the Army Medical Command (MEDCOM). The Surgeon General is the medical expert on the Army staff, advising the Secretary of the Army, Army Chief of Staff, and other Army leaders. The Surgeon General develops the policy and budgets. As, the Commanding General (CG) of MEDCOM, the CG is responsible for the delivery of healthcare in the Army's military treatment facilities and executes the budgets and policies.

The Army Medical Command has numerous subordinate commands including five Regional Medical Commands, the Warrior Transition Command, and the Army Medical Department Center and School. The Regional Medical Commands oversee the operations, staffing and resourcing of the military treatment facilities in their area of geographic responsibility. The military treatment facilities are hospitals, medical centers, clinics, or medical care sites. The WTU is a subordinate command of the military treatment facility that is responsible for the complex medical case management of seriously wounded, injured, or ill Soldiers.

The Warrior Transition Command is the MEDCOM subordinate organization responsible for managing the Army's Warrior Care and Transition Program (WCTP); coordinating wounded, ill, or injured Soldiers movement; implementing the Recovery Coordination Program and Comprehensive Transition Plan; and assisting WTC and AW2 Soldiers, Veterans, and their Families with career and education opportunities. The WTC ensures the standardization of the implementation of the WCTP program across the Army.

The Office of the Surgeon General Medical Command Policy Memo 11-098, November 29, 2011, "Comprehensive Transition Plan (CTP) Policy," stated that all Soldiers, regardless of CTP track, would complete six CTP processes. These processes overlap, interrelate, and include multiple interconnected feedback loops. All Soldiers will complete in-processing, phase I goal setting training, initial self-assessment, CTP track selection, and initial scrimmage within 30 days of arrival at a WTU, which will be documented using the automated CTP, counseling records, and AHLTA.[27] Specifically, these six processes included:

- In-processing – lays the foundation for integration into the WTU/CBWTU and initiates the CTP
- Goal Setting – guides the Soldier and his Family in the development of sub-goal (short-term) and transition outcome goal (long-term). The Specific, Measurable, Actionable, Realistic, and Time Bound (SMART) Action Statements provides the Soldier a roadmap that supports healing and transition

[27] Armed Forces Health Longitudinal Technology Application (AHLTA) is the clinical information system that generates and maintains a lifelong, computer-based outpatient record for every Soldier, Sailor, Airman, and Marine; their family members; and others entitled to DoD military care who receives care in a military treatment facility.

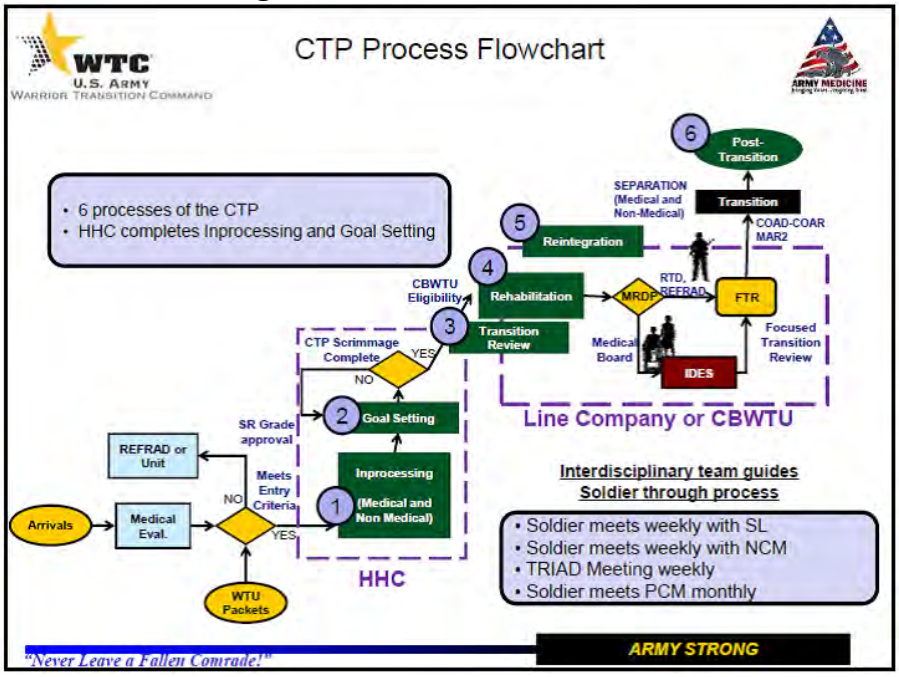
- Transition Review – provides the interdisciplinary team with an opportunity to review Soldier goals and progress with a focus on identifying and resolving issues that are impeding goal attainment. This process includes self-assessment and scrimmage steps:

    - Self-Assessment – designed to facilitate weekly discussions between the Soldier and his Squad leader or Platoon Sergeant and Nurse Case Manager
    - Scrimmage – a formal meeting with the Soldier's interdisciplinary team that uses six domains of strength (career, physical, emotional, social, Family and spiritual) to develop and refine a future oriented Transition Plan
    - Focused Transition Review (FTR) – a formal meeting that is similar to scrimmage, but focuses more on the transition plan progress and development of a new plan to track remaining actions and sub-goals. Acts more as a feedback and an after action review of the process for each Soldier and the supporting interdisciplinary team
    - Synchronization of the scrimmage and FTR timelines – FTR's augment and provide additional company and battalion level focus to quarterly scrimmages

- Rehabilitation – provides appropriate clinical and non-clinical interventions to support the Soldier's transitional goals
- Reintegration – designed to specifically prepare each Soldier and his Family for a successful transition back to the force or to civilian life as a Veteran
- Post-transition – refers to the period after a Soldier has exited the WTU/CBWTU. The Soldier is under the guidance of his gaining unit, the VA, and/or the AW2[28] Program, if eligible. Figure 1 illustrates the six processes of the CTP as described above.

[28] Army Wounded Warrior (AW2) is an Army program that assists and advocates for severely wounded, ill, and injured Soldiers, Veterans, and their Families, wherever they are located, regardless of military status. The system of support and advocacy uses a non-medical case management model to help guide severely wounded, injured, and ill, Soldiers from evacuation, through treatment, rehabilitation, return to duty or military retirement and transition into the civilian community. AW2 works inside the network of Army, Government, and local and national resources to help Soldiers and Families resolve many issues and foster independence into the next stage of their lives.

Figure E-1. CTP Process Flowchart



Source: Warrior Transition Command, Comprehensive Transition Plan Policy and Guidance – December 1, 2011

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Appendix F. Medical Evaluation Board Background

The MEB is the process designed to determine whether a Soldier's long-term medical condition enables him/her to continue to meet medical retention standards. The MEB is an informal board process because, by itself, it does not drive any personnel actions.

Initiation of Medical Evaluation

Soldiers receive referral for medical evaluation when a question arises as to the Soldiers' ability to perform the duties of his or her office, grade, rank, or rating because of physical disability. The referral could occur through the Army Surgeon General to the responsible MTF, directly from the MTF treating the Soldiers, or from the unit commander to the MTF for evaluation.

Medical Examination Related to Disability Evaluation

The MTF commander having primary medical care responsibility will conduct an examination of Soldiers referred for evaluation. The commander will advise the Soldiers' commanding officer of the results of the evaluation and the proposed disposition. If it appears that the Soldiers are not medically qualified to perform duty, the MTF commander will refer the Soldiers to a MEB.

The Medical Evaluation Board

The convening of the MEB is to document the effect of the Soldiers' medical status and duty limitations on their ability to perform their duty. The MEB determines whether the Soldier is medically qualified for retention. If the MEB determines that the Soldier does not meet retention standards, the board will recommend referral of the Soldier to a PEB.

Narrative Summary

The narrative summary (NARSUM) is the basis for the MEB and the disability evaluation system. Incomplete, inaccurate, misleading, or delayed NARSUMs may result in injustice to the Soldier or to the Army. The NARSUM documents the history of the Soldier's illness, objective findings on examination, results of radiology and laboratory tests, reports of consultations, response to therapy, and addresses the subjective conclusions with rationale. The NARSUM shows the correlation established between the Soldier's medical defects and physical capabilities. This is important when a chronic condition is the basis for referral to a PEB and no change in severity of the condition has occurred or when referral of the case to a PEB appears controversial. The date of onset of a medical impairment may be questionable because of relatively short military service and the nature of the impairment, for example, a mental disease. If so, the NARSUM should address the results of inquiry into the pre-service background (family, relatives, medical, and community) of the Soldier in sufficient detail to overcome substantive question concerning the date of onset. When a Soldier has a diagnosis with a mental disorder, the NARSUM must include a statement indicating whether the Soldier is mentally competent for pay purposes and capable of understanding the nature of, and cooperating in, PEB proceedings. NARSUMs will not reflect a conclusion of unfitness. When disclosure of medical information would adversely affect the Soldier's physical or mental health, the NARSUM should include a statement to that fact. Finally, the NARSUM should include the date of the physical examination conducted for purposes of physical disability evaluation.

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Appendix G. Management Comments

Office of the Surgeon General, U.S. Army Medical Command

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042-5140

REPLY TO ATTENTION OF

DASG-ZA

02 JUL 2013

MEMORANDUM FOR Department of Defense Inspector General, Special Plans and Operations, ATTN: [redacted] 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: Reply to DODIG Draft Report, Assessment of Wounded Warrior Matters, Fort Riley, (Project No. DODIG 10SP-0209.004)

1. Thank for you the opportunity to review this report. Our comments are enclosed for your consideration.

2. Our point of contact is Ms. Carmen C. Bryan, [redacted]

FOR THE SURGEON GENERAL:

Encl

DAVID A. BITTERMAN
Colonel, MS
Chief of Staff

U.S. Army Medical Command (MEDCOM) and
Office of the Surgeon General (OTSG)

Comments on DODIG Draft Report
Assessment of DOD Wounded Warrior Matters – Fort Riley
(Project No. D201O-D00SPO-0209.004)

RECOMMENDATION C.1.1.a.: Evaluate the current and future cadre personnel requirements of the Warrior Transition Units to ensure that the staffing levels, including squad leaders and Nurse Case Managers, are appropriate to meet the mission for effective management and support of Soldiers during their healing and transition.

RESPONSE: Concur. WTC conducts periodic reviews of the Warrior Transition Unit (WTU) Table of Distribution and Allowance (TDA). During this process, WTUs are structured based on forecasted Warrior in Transition (WT) population. The forecast models Pre-Deployment, Theater Evacuation, and Post-Deployment gains into the WTU population while accounting for actual deployment schedules into the future. This process ensures WTUs are adequately designed to support WT population increases on installations, but also allows the TDA to be streamlined for installations with WT populations trending downward.

WTC recently revised the cadre assignment policy to ensure best-qualified personnel are selected. The policy is undergoing final revision and should be issued by 30 August 2013.

In addition, WTC received approval to: (i) have key billets for the Command Section List incorporated once approved by HRC; and (ii) continue to fill Contingency Operation for Active Duty Operational Support positions as required, and use 2-year permanent change of station orders instead of 1-year orders.

These actions should ensure appropriate staffing to meet the mission and effectively manage and support Soldiers during their healing and transition.

RECOMMENDATION C.1.1.b.: Conduct an analysis to determine whether the Warrior Transition Units/Warrior Transition Battalions have adequate funding and other resources to support the necessary level of WTB personnel, ongoing staff training requirements, and support services in order to maintain optimal staffing levels and ratios.

RESPONSE: Concur. In December 2012, the US Army Manpower Analysis Agency (USAMAA) validated the WTU Ratio Determination Model for use in determining manpower requirements for all WTUs and Community Care Units. USAMAA approved the model application for 3 years (see attachment 1, USAMAA Validation).

Encl

With the significant decrease in supplemental funding occurring now through FY 15, funding for Reserve Component Soldiers continues to be an issue. Therefore, WTC requested DA consider an alternate sourcing solution to continue required Reserve Component support. DA agreed to maintain staffing levels as currently resourced to meet present and future wounded warrior requirements. On 6 February 2013, HQDA published EXORD 079-13, Warrior Care and Transition Program CO-ADOS Exemption Approval and 730-Day CO-ADOS Order Implementation Guidance (attachment 2, EXORD 079-13). HQDA approved full exemption of the Warrior Care and Transition Program (WCTP) CO-ADOS requirements.

Analysis is conducted annually to ensure adequate funding to support personnel, training, and support services for WTUs. As a result, WTUs have consistently been fully funded and adequately resourced for the conduct of their mission. It is anticipated that resources will remain adequate through FY18 in accordance with programming. Though funding is adequate, restrictions on hiring, travel, and contract spending continues to impact the program.

RECOMMENDATION C.2.1.a.: Complete the migration of the Comprehensive Transition Plan from the Army Knowledge Online to the Army Warrior Care and Transition System.

RESPONSE: Concur. Migration of the Comprehensive Transition Plan (CTP) from Army Knowledge Online to the Army Warrior Care and Transition System was completed in June 2012, in accordance with the timeline provided in Annex A to WTC Operation Order 11-10 (see attachment 3, WTC Operation Order 11-10).

RECOMMENDATION C.2.1.b.: Review the Comprehensive Transition Plan policy and guidance for relevance and effective content in supporting Soldier and Family transition needs.

RESPONSE: Concur. WTC will review and update CTP policy and guidance by 31 December 2013. Lessons learned from leaders and the field will be incorporated to ensure Soldiers and Families receive the best transition assistance and care possible.

Pending Army Regulation 40-xx, Warrior Care and Transition Program, will serve as the source document to synchronize the command's efforts of caring for our Soldiers. The regulation is currently being staffed throughout DA for feedback. We anticipate submitting the regulation to the Army Publication Directorate by 30 Sept 2013.

RECOMMENDATION C.2.2.: Commander, Warrior Transition Battalion, assess the effectiveness of WTB leadership and cadre in actively engaging the Soldiers' CTP and encouraging Soldiers' involvement and adherence to the plan for a successful transition.

RESPONSE: Concur. At the time of inspection, the Fort Riley Warrior Transition Battalion (WTB) had a large caseload, which included a relatively high number of high-risk Soldiers. The WTB was staffed to care for 312 Soldiers in transition; however, over 345 Warriors were assigned, including about 15-20 high-risk Warriors and ratios were approximately 1:15 for squad leaders and 1:24 for nurse case managers. Fort Riley's WTB triaged excessive workload by prioritizing high-risk and acute Soldiers to ensure their safety; as a result, there was a steep decline in the CTP process and automated CTP (aCTP).

Currently, there are 209 Soldiers assigned to the WTB; ratios are: squad leader, 1:6; platoon sergeant, 1:19; nurse case manager, 1:10; and behavioral health 1:42. The Triad of Care and Interdisciplinary Teams are able to effectively manage all of the WTB Warriors, including high-risk Soldiers, ensuring all required CTP steps are satisfactorily completed.

The aCTP was cumbersome and difficult to use; information was not was not streamlined, and cadre couldn't provide effective and timely Warrior input to the system. The Army Warrior Care and Transition System (AWCTS) has greatly improved these issues and allows for necessary information to be stored in one central location, enabling all stakeholders to view and make timely adjustments and decisions. All cadre and Warriors are briefed on AWCTS. CPTs are treated as binding documents requiring accurate and timely input. The Fort Riley WTB continues to ensure AWCTS is a main priority and strives for a 100 percent compliance rate.

RECOMMENDATION D.1.1.: Commander, Western Regional Medical Command track each phase of the Integrated Disability Evaluation System (IDES) process to identify and resolve the barriers to timely IDES completion for Soldiers assigned or attached to WTBs.

RESPONSE: Concur. During June 2012, Western Region Medical Command (WRMC) developed and staffed a new Integrated Disability Evaluation System (IDES) section within the Warrior Transition Office (WTO) to identify, monitor and analyze trends and conditions affecting timely and efficient disability processing for WTB Soldiers. EXORD 80-12, 17 February 2012 established the Veterans Tracking Application (VTA) as the system of record for selected measures. It is updated and used by IDES stakeholders, including Physical Evaluation Board Liaison Officers (PEBLO); the Physical Evaluation Board (PEB); and the VA Disability Evaluation System Rating Activity Sites (DRAS), and allows the WTO to track each phase of the IDES process (see attachment 4, Weekly IDES Update).

To improve timeliness, WRMC instituted a monthly teleconference review with military treatment facilities to discuss each case where a WTB Soldier's case is delayed in the MEB phase greater than 150 days. MTFs complete detailed status information, including planned actions and obstacles prior to the teleconference, and the WTO provides immediate guidance as each case is reviewed during the teleconference. This continuing action has resulted in a significant decrease in WTC cases delayed in the MEB phase (see attachment 5, MEB Phase Average Days).

As a result of this success, WRMC expanded this monthly teleconference review to include all WRMC Soldiers in the MEB phase greater than 150 days, beginning 29 March 2013 (see attachment 6, Tasking 130308-03).

A backlog at the VA DRAS, used for applying disability ratings to claimed conditions acquired during service, has been identified as an additional barrier to timely processing. MEDCOM is sending 15 Soldiers to provide administrative support beginning 6 May 13. The impact of this team will be evaluated after 6 months to determine if more support is needed.

In March 2013, the WTO also began monitoring all WTB Soldiers in the MEB phase of IDES for more than 100 days, and will provide this information to the WTBs each month during the WRMC WTB Nurse Case Manager meeting. This information will be used to determine what other actions could further improve the overall timeliness of disability processing for Soldiers.

RECOMMENDATION D.1.2.a.: Identify obstacles within the Soldiers' MEB referral, claim development, medical evaluation, and MEB processing phases that inhibit prompt MEB completion, and provide sufficient staff support for Physical Evaluation Board Liaison Officers and ensure that staff to Soldier ratio is sufficient to ensure timely processing of MEB packages.

RESPONSE: Concur. Since its initiation in February 2010, Fort Riley IDES has been in a state of constant change. Over the last 2 years, IDES staff grew to include 30 PEBLOs, 21 PEBLO assistants, 8 providers and 3 behavioral health providers in November 2012. In January 2013, IACH reached and has continued to meet MEDCOM's 100-day standard (see attachment 7, Quarterly IDES Brief). Currently, Fort Riley has 19 PEBLOS, 14 PEBLO assistants, 5 providers and 3 behavioral health providers.

During Fall 2012, IDES began using the Strategic Management System (SMS) for all IDES data collection and reporting. This tool updates data weekly from both the VTA and eMEB. IDES staff continues to closely monitor IDES data providing weekly reports on their analysis to the Commanding General, Fort Riley (see attachment 4, Weekly IDES Update) and making improvements as needed.

Currently, IACH has a total of 1,110 IDES cases in the system. Over 50 percent of these cases are either transitioning out of the military, or are already out and pending receipt of their VA benefits. Only 13 percent of total IDES cases are in the MEB portion of IDES. IACH reviews: (i) PEBLO and provider productivity weekly, using the information to inform appraisals; (ii) average processing time for all data points; (iii) the percentage of cases meeting the standard; and (iv) on a monthly basis, the number of IDES cases assigned to each PEBLO and where they are in the process.

IACH is meeting Phase 1-A, B, C, and D processing time and has been meeting the overall MEB timelines since January 2013, and is striving to meet subphase 1-D, the Narrative Summary (NARSUM) (see attachment 4, Weekly IDES Update). The MEDCOM standard is 5 days; however, IACH has averaged about 10 days during the last 2 months, and is working toward meeting the standard.

In addition to these efforts, Fort Riley has continued to improve the relationship with the VA, meeting weekly with both the Veteran's Benefit Administration (VBA) and the Veteran's Health Administration (VHA). VA staff has grown in support of the IDES mission in the last 2 years, and are equally important in the IDES process.

RECOMMENDATION D.1.2.b.: Educate Soldiers and their families on how to execute the IDES process to include a realistic timeline for what the Soldier can expect once the process begins.

RESPONSE: Concur. Education begins when Soldiers enter the IDES process and continues throughout. Immediately after initiation into IDES, Soldiers are required to attend a multidisciplinary IDES Welcome that is hosted by all key members of IDES. This provides an overview of the process and starts the education process. This is immediately followed by an introductory meeting with the Soldier MEB Counsel where they help establish realistic expectation management. Education continues as Soldiers meet with their PEBLO, MSC, VA provider, and NARSUM writer. All provide information throughout the IDES process which is specific to the Soldier's case. The PEBLO becomes the key component once the case is submitted to the PEB.

In addition, leaders are educated through interaction with PEBLO Supervisors and at Commander and First Sergeant Pre-Command course

RECOMMENDATION D.1.2.c.: Develop a mechanism whereby a Soldier can track and be informed of his or her status in the IDES process.

RESPONSE: Concur. The PEBLO is the Soldier liaison through the process and is their first stop for all questions about the IDES process. Soldiers also have an option to use My MEB through AKO. This system has been unreliable in the past, but now pulls

information from all IDES data sources, including eMEB and VTA. Information available is dependent on the timeliness of the data owner's input. Data points belong to key players in the process, including PEBLO, MCS, PEB, DRAS, and PDA. PEBLOs are instructed to call Soldiers weekly to update them on the status of their case. Once the case moves into Phase 2, that weekly requirement is changed to every 2 weeks. PEBLO teams meet with units monthly to provide status updates on Soldiers, and PEBLOs are always available to both Soldier and command to answer any questions. Currently, IACH is having difficulty identifying an exact case location once the case is forwarded to DRAS. This is a recognized problem across DOD and we expect visibility will improve as the VA applies additional resources to the issue.

RECOMMENDATION D.2.1.: Commander, United States Army Medical Command develop options for increasing the number of behavioral health personnel at Fort Riley Irwin Army Community Hospital to support the numbers of Soldiers requiring such care and to accelerate MEB processing.

RESPONSE: Concur. Army Medical Command will continue to assess projected behavioral health workload at Fort Riley. We anticipate that the new Professional Services Model will be applied to the Table of Distribution and Allowances by 1 January 2014, which will further adjust the behavioral health provider template at Fort Riley.

Per Army Regulation 570-4, manpower requirements are based on workload documented in authoritative systems. Army manpower models for medical treatment facilities are based on workload documented in Armed Forces Health Longitudinal Technology Application; Workload Management System for Nursing (Internet), Defense Medical Human Resource System – Internet; and other systems; and adjusted for anticipated changes in supported populations.

Based upon behavioral health documented workload at Irwin Army Community Hospital, the Table of Distribution and Allowances manpower requirements and authorizations for behavioral health providers and support staff at Fort Riley has nearly doubled since 2010. With the announced reductions in force structure at Fort Riley decreasing the Active Duty end strength by about 1,700 soldiers and their family members, it is highly unlikely that further increases in the number of behavioral health providers will be warranted in the face of an 11.6 percent reduction in the number of beneficiaries served. In addition, the capacity of the WTU at Fort Riley is scheduled to be reduced from 400 to 270 on 1 October 2013 (see attachment 8, GOSC Executive Summary), further reducing the need for additional behavioral health capacity at Irwin Army Community Hospital.

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Special Plans & Operations

Provide assessment oversight that addresses priority national security objectives to facilitate informed, timely decision-making by senior leaders of the DOD and the U.S. Congress.

General Information

Forward questions or comments concerning this assessment and report and other activities conducted by the Office of Special Plans & Operations to spo@dodig.mil

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